

Yeshasvini Trust, Karnataka India

CGAP Working Group on Microinsurance
Good and Bad Practices
Case Study No. 20

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Good and Bad Practices in Microinsurance

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1. A **series of case studies** to identify good and bad practices in microinsurance
2. A **synthesis document** of good and bad practices in microinsurance for practitioners based on an analysis of the case studies. The major lessons from the case studies will also be published in a series of **two-page briefing notes** for easy access by practitioners.
3. **Donor guidelines** for funding microinsurance.

The CGAP Working Group on Microinsurance

The CGAP Microinsurance Working Group includes donors, insurers, and other interested parties. The Working Group coordinates donor activities as they pertain to the development and proliferation of insurance services to low-income households in developing countries. The main activities of the working group include:

1. Developing donor guidelines for supporting microinsurance
2. Document case studies of insurance products and delivery models
3. Commission research on key issues such as the regulatory environment for microinsurance
4. Supporting innovations that will expand the availability of appropriate microinsurance products
5. Publishing a quarterly newsletter on microinsurance
6. Managing the content of the Microinsurance Focus website:
www.microfinancegateway.org/section/resourcecenters/microinsurance

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The authors

Acronyms

CGHS	Central Government Health Scheme
DICGC	Deposit Insurance and Credit Guarantee Corporation
DRCS	Deputy Registrar of Cooperative Societies
ESIS	Employees’ State Insurance Scheme
FHPL	Family Health Plan Limited
FICCI	Federation of Indian Chambers of Commerce and Industry
GIC	General Insurance Corporation
IRDA	Insurance Regulatory and Development Authority
OPD	Outpatient Department
TPA	Third Party Administrator
ILO	International Labour Organization
GTZ	German Technical Assistance
SIDA	Swedish International Development Agency
DFID	Department for International Development
CGAP	Consultative Group to Assist the Poorest
NGO	Non-governmental organization

Executive Summary

The Yeshasvini Cooperative Farmers Health Scheme is a young but incredibly successful microinsurance scheme in Karnataka. Having started in 2003 with 1.6 million insured right away, it covered 2.2 million lives in its second year of operation, but in the third year it dropped to 1.45 million members after doubling the premium. This (still) amazing success is possible through a tight partnership with the cooperative sector enabled through the Karnataka Department of Cooperation. The department used its influence to encourage cooperative societies to market the product actively. The marketing strategy applied by the societies' secretaries varies: while most convince their members to join, a few simply enrolled their members.

Yeshasvini Trust decided to design a benefit package focussing on high cost / low frequency events. More than 1,600 surgeries are covered under the scheme. The maximum coverage provided for one person per year amounts to Rs. 200,000 (\$4,545). The annual premium per client was recently increased from Rs. 60 (\$1.40) to Rs. 120 (\$2.70). A person can claim the benefits in one of 150 (mainly) private hospitals aligned with the insurance scheme. A rate for each surgery is fixed. Additionally, free outpatient department (OPD) treatment is provided. The patient does not need to handle money; the insurer pays the health care provider for pre-approved surgeries, so the service is cashless to the policyholder.

Yeshasvini is a self-funded scheme and not linked to any insurance company. It outsources the administration of the scheme to a Third Party Administrator, a profit-oriented company. This company authorizes surgeries, processes claims and maintains a register of the members.

The scheme received government subsidies in all years of operation. With the increased premium in the third year, the scheme is expected to get closer to financial viability.

Although Yeshasvini can use the cooperative structures to channel information to clients, many policyholders are not well informed about the benefits and how to claim them.

Lessons: Organisational Structure

- With the cooperative sector, Yeshasvini found a partner reaching out to the rural masses, which has proved to be a strong distribution network. This stable structure helped to quickly build up a huge membership.
- Political involvement can push the development of the scheme forward; but one has to be cautious not to lose sight of the initial motivations in the scheme.
- Yeshasvini lined up about 150 high-quality hospitals. The good reputation of these hospitals contributes to the attractiveness of the scheme.
- The business relationship between cooperative societies and their members helps in the subscription periods of the scheme: members are in regular contact with their cooperative society anyway and can deduct the premium for the insurance directly from their business income.

- Yeshasvini operates in a huge geographic area. The centralized structure (e.g., authorisation) leads to unnecessary bottlenecks and delays in the process. More authority should be given to the districts with the central bodies focussing on overall monitoring and control.

Lessons: Insurance Product

- Sophisticated quality surgery in modern facilities can be made available to the poor.
- Even expensive surgeries can be covered if the number of insured is big enough to avoid strong effects of adverse selection. Single surgeries of up to Rs. 96,000 (\$2182) are covered.
- Without the scheme, many beneficiaries would not have been able to obtain the surgery they have received. Yeshasvini helped to save a number of lives.

Lessons: Claim Process

- It is possible to provide cashless health care services to the poor. But the price of providing cashless services is a pre-authorisation for surgery, taking days to be issued.
- Long authorisation for surgery constitutes a burden to poor clients as they might need to travel to the hospital twice or face the (opportunity) costs of waiting.
- A professional administrator is necessary for large schemes like Yeshasvini. However, clear administrative procedures have to be designed to serve the clients first. Holding back reimbursement to the hospital might be a more appropriate procedure than holding back authorisation for surgery.

Lessons: Distribution and Marketing

- Increasing premium together with insufficient information results in high rates of non-renewal.
- Relying on the strong and partly hierarchical structure of the cooperative sector, the scheme neglected extensive communication to the client. Many clients are not aware about the details of the benefit package and how to obtain them. This often leads to unnecessary dissatisfaction.
- If policyholders can decide whether or not to insure other members of their households, adverse selection is likely to occur. This effect can be reduced by offering a special rate when insuring all household members.
- Adverse selection also occurs since ill clients can join the scheme. A screening procedure needs to be defined to address this issue. The right procedure could again be an incentive for households to join as a whole.

1. The Context¹

The subcontinent of India is home to more than one billion people. India is organised as a federal republic of 24 states and 7 union territories. It is characterised by much diversity of people, languages, religions and cultures. India's society is stretched between traditions and influences coming from outside. From a socio-economic point of view, India represents a massive dichotomy between the majority of relatively poor people, and a growing minority of people, who are becoming more affluent, with a few very rich families. The country's economy is growing rapidly.

Table 1.1 Macro Data

GDP (US\$ Billions)	Purchasing power parity - \$3.319 trillion (2004 est.) ²
Population (millions)	1,080,264,388 (July 2005 est.) ¹
Population density per km ²	324/ sq km ¹
Percentage urban / rural population	30.5% / 69.5% ³
GDP/Capita (US\$)	Purchasing power parity - \$3,100 (2004 est.) ¹
GDP Growth Rate	6.2% (2004 est.) ¹
Inflation	5.4% (2002 est.) ⁴
Exchange Rate (Indian Rupees to US\$1) ⁵	Rs. 44 (in March 2005) ⁶
PPP GDP per Capita	2,840 (in 2001) ⁷
Infant Mortality (per 1000 live births)	56.29 deaths/1,000 live births ¹
Under Five Mortality (per thousand)	87.0 ⁸
Maternal Mortality (per 100,000 live births)	540 (in 2001) ⁶
Access to safe water (% of population)	86 % ⁷
Total Health Expenditure as % of GDP (public/private/total)	0.9%/ 4 %/ 4.9 % in 2000; in 2001 5.1% (total) ⁹
Out-of-Pocket Spending as % of total health expenditure	77.5% (2002) ¹⁰
Total Health Expenditure per capita (US\$)	\$18 (in 1999) ¹¹
Doctors per thousand people	0.48 (in 2002) ⁶
Hospital beds per thousand people (urban/rural)	0.8 (in 1999) (total) ⁹
Literacy rate	Definition: age 15 and over can read and write total population: 59.5% male: 70.2% female: 48.3% (2003 est.) ¹

¹ A more comprehensive description of the Indian context (including regulation, insurance industry situation) can be found in Radermacher et al (2005), "Karuna Trust," Case Study #19 of this series.

² <http://www.cia.gov/cia/publications/factbook/geos/in.html#Intro>

³ <http://www.unhabitat.org/habrrdd/conditions/socentasia/india.htm>

⁴ <http://www.capitals.com/print/in.html>

⁵ This exchange rate will be used in all calculations of current figures in this paper.

⁶ <http://www.economywatch.com/indianeconomy/indian-economy-overview.html>

⁷ http://www.undp.org/hdr2003/indicator/cty_f_IND.html

⁸ <http://devdata.worldbank.org/external/CPPProfile.asp?SelectedCountry=IND&CCODE=IND&CNAME=India&PTYPE=CP>

⁹ http://www.who.int/macrohealth/action/en/rep04_india.pdf

¹⁰ Calculated from World Health Report 2005, Statistical Annex, Tables 5 & 6, <http://www.who.int/whr/2005/annex/annex5.xls>, <http://www.who.int/whr/2005/annex/annex6.xls>

¹¹ http://www.worldbank.org/data/wdi2000/pdfs/tab2_14.pdf

1.1 Role of the State in Insurance

Insurance business is a federal responsibility. Following the Insurance Regulatory and Development Authority (IRDA) Act 1999, the formerly nationalized insurance industry in India is partly privatised, although the government has still a strong influence in insurance operations.

Insurance providers are allowed to provide either life or general insurance; health insurance can be provided by either type. In the Insurance (Amendment) Act 2002, four types of insurance providers are mentioned:

- a. Insurers registered under the Companies Act 1956
- b. Provident societies,
- c. Mutuals providing insurance policies, and
- d. Cooperative societies providing life insurance.

Mutuals and cooperatives are also regulated under state acts; the Insurance (Amendment) Act 2002 refers to certain state responsibilities in this respect.

The requirements for insurers in the Insurance (Amendment) Act 2002 are focused inter alia on registration, reporting, auditing, excess capital to absorb shocks, assets allocation and valuation, contractual issues, managerial qualifying conditions and agents. However, these requirements differ according to the legal entity operating insurance business.

The capital requirement consists of three components: a) paid up capital before registration can be applied for (which requires a registration fee that needs renewal on a regularly basis); b) deposited capital; and c) working capital (or the “solvency margin”, defined as the surplus of assets over liabilities). For commercial insurance companies, the following requirements are in place:

1. The paid up capital requirements are Rs. 1 billion (\$ 22.7 million);
2. Registration fee = a function of premium with a maximum of Rs. 50,000 per insurance class,
3. Deposited capital is a function of total gross premium written with a maximum of Rs. 100 million (\$ 2.3 million), and
4. Working capital is a function of premium, reserves and reinsurance, or claims with a maximum of Rs. 500 million (\$11.4 million).

The requirements for provident societies, mutuals and cooperative societies mentioned in the Insurance (Amendment) Act 2002 are different with respect to capital requirements including registration (as shown in Table 1.2); there are also key differences in reporting and auditing.

Table 1.2 Requirements for Mutual/Cooperative Insurers

	Mutual Insurance Companies	Cooperative Life Insurance Societies
Paid up capital	Rs. 15,000 (*)	Rs. 15,000
Registration fee	n.a.	n.a.
Deposit capital	Rs. 200,000 (**)	Rs. 200,000 (**)

* Capital requirements are not further specified in the Act; may be paid up capital, or surplus capital.

** Deposits explicitly mentioned for life insurance; not general insurance.

n.a. = not available in Insurance (Amendment) Act 2002.

Provident societies are limited in the provision of benefits in type and amount. The cooperatives mentioned provide life insurance and the mutuals are not explicitly restricted in their activities. They all are required to be non-profit organizations.

IRDA is aware of the need for and importance of grassroots microinsurance schemes. The Concept Paper on Need for Developing Micro-Insurance in India (August 18th, 2004, issued by IRDA) promotes the partner-agent model to increase coverage for the rural population. In a recent Round Table with the IRDA in Hyderabad (February 19th, 2005), other prevalent types of microinsurance models were discussed, as well as ways to strengthen them.

In November 2005, IRDA issued microinsurance regulation for the partner-agent model. Microinsurance agents (e.g., non-governmental organisations (NGOs)) are allowed to tie up with only one life and one general insurance company at a time. These companies can partner in the development of an appropriate microinsurance product. IRDA sets a framework for the design of the partner-agent relationship but defines some issues clearly; for example, each agent should receive at least 25 hours of training at the expense of the insurer. IRDA also fixes the commissions payable to the agent, as well as maximum and minimum coverage for different insurance classes. Models other than partner-agent are not part of the regulation.

1.2 Insurance Industry Basics

After a period of nationalized insurance, in 1999 private providers again gained access to the market if they are Indian companies or were founded as joint ventures with foreign shares no larger than 26%. The General Insurance Corporation (GIC) came to play the role of a national reinsurer, and its four subsidiaries, which are still state-run, entered into competition with each other and private providers. The state-run companies still dominate the health insurance market with their products.

To date, eight private insurers are registered in general insurance. On average, the market for health insurance has grown at a rate of 40% in the three years following 1999 and therefore presents the fastest growing market in the general insurance industry. However it still has low market penetration. According to estimates, only 10% of the market has been explored – an exploration of 35% over the next years is seen as realistic (Bhat/Mavalankar 2000).

In pursuing social goals, the IRDA requires that at least 5% of all general insurers' gross premiums collections must originate from contracts with the rural population after the third year of business operations (IRDA 2000). However, only very few companies regard the regulator's rural and social obligations as business opportunities rather than just obligations. Nevertheless, the number of policies with poor customers increases with increasing penetration of the upper market.

The Most Popular Health Insurance Products

The most popular private, voluntary health insurance product in India is Mediclaim, which has been offered by all four state-run insurance companies since 1986 and was used by 10 million Indians in 2004/05. Mediclaim reimburses costs of hospital stays and home care up to an individually determined sum (Bhat/Mavalankar 2000). The premium depends on the sum covered (between Rs. 15,000 (\$340) and Rs. 500,000 (\$11,363)) and the age of the insured

person. (Bhat/Babu 2003) Since the premium is income-tax deductible, the state thereby subsidises 20-40% of the premium (Bhat/Mavalankar 2000). Besides policies for individuals, family or group policies are possible with premium discounts up to 30% (Gumber 2002).

Following the example of private providers, the state-run insurance companies have recently begun to integrate private Third Party Administrators (TPAs) in servicing their clients. TPAs look after the client and pay for the services on behalf of the insurance company. They also monitor health services and billing by keeping close contact with a network of health care service providers on behalf of insurance companies (IRDA 2002).

As smaller variant of Mediclaim, the Jan Arogya Bima policy, aims at poor population groups and accounts for 400,000 of the Mediclaim policyholders (Krause 2000) and is one of the most important health insurance products for low-income groups. The benefits of the Jan Arogya Bima policy are limited to hospital stays with an annual limit of Rs. 5,000 (\$113). The age-dependent premiums range between Rs. 70 (\$1.60) and Rs. 140 (\$3.20). Children under 25 years of age can be co-insured for Rs. 50 (\$1.1).

In 2003, on an initiative by the Minister of Finance, the state-run insurance companies introduced Universal Health Insurance. It is offered at a price of Rs. 365 per year (political slogan: “For a rupee per day”) for a single person; Rs. 548 (\$12.50) for a family of five (with three children); or Rs. 730 (\$17) for the family plus two dependant parents. Families living below the poverty line receive a annual subsidy from the central government of Rs. 200 (\$4.60) for an individual, up to Rs. 400 (\$9.10) for a family of seven. At the end of March 2004, 417,000 families with 1.16 individuals were covered (Gupta 2005). Hospital stays are covered up to a total amount of Rs. 30,000 (\$682) per year for all family members (so-called “family floater”). A single hospital stay must not exceed Rs. 15,000 (\$341) (Ahuja 2004). Also, for the primary income-earner sickness benefits of Rs. 50 (\$1.10) per day are paid as a compensation for lost income if hospital stays exceed 3 days.

As an alternative to the acquisition of private insurance, many employers try to protect their employees from high health care expenditures through their own health insurance plans or health care service providers (Ellis/Alam/Gupta 2000). As shown in Table 1.3, these employer-based systems, offered by the postal service or railway for example, are estimated to insure 20 to 30 million persons (Bhat/Mavalankar 2000).

Table 1.3 Selected Health Coverage in India

Source of Coverage	Covered Lives (Thousands)
Central Government Health Scheme	4,276
Mediclaim	10,000
Universal Health Insurance Scheme (rupee-a-day)	1,600
Employees' State Insurance Scheme (ESIS)	31,050
Government Non-Life Insurance Companies	56
Non-Government Non-Life Insurance Companies	13
Employer sponsored	30,000

(source: FICCI survey 2004; Cahill/Matthies 2005; figure for UHI: Gupta 2005)

Table 1.4 Insurance Industry Basics

Issues	Observations
Name of insurance regulatory body	Insurance Regulatory and Development Authority
Key responsibilities of the regulatory authority	Regulating, promoting, supervision, licensing, ensuring orderly growth, protection of policyholders
Minimum capital requirements for insurance license	Rs. 1 billion (\$22.7 million) for life and non-life insurance sector respectively
Other key requirements for an insurance license	So far, insurance companies can only either engage in life or general insurance business.
On-going capital requirements for an insurance company	- Valuation of assets and liabilities is done in the prescribed format of IRDA to calculate the required solvency margin. - For life insurance, required solvency margin is higher of either Rs. 500 million (\$11 million) or an aggregate sum of the results arrived after valuation of assets and liabilities. - For non-life insurance, required solvency margin is higher of either Rs. 500 million (\$11 million) or sum equivalent to 20% of net premium income or a sum equivalent to 30% of net incurred claims
Other key requirements for regulatory compliance	- Companies have to comply with the solvency margin ratio. - Accounting and Reporting to IRDA annually - Companies must comply with social and rural sector obligations - Companies must comply with investment regulations.
Minimum capital requirement for reinsurer	Rs. 2 billion (\$46 million) for reinsurance business
Annual premiums of regulated private insurers (2004-05)	- Rs. 55.6 billion (\$1.3 billion) for 13 life insurers - Rs. 35.5 billion (\$806 million) for 8 general insurers
Annual premiums of regulated public insurers (2004-05)	- Rs. 197.9 billion (\$4.5 billion) for 1 public life insurer - Rs. 140.5 billion (\$3.2 billion) for 4 general insurers
Number and type of other regulated insurance organizations	DICGC (Deposit Insurance and Credit Guarantee Corporation)
Number of re-insurers (if any)	1 national reinsurer – GIC of India (however private reinsurers have offices in India and they procure the business through them, including Swiss Re, Munich Re, and RGA Reinsurance)
Annual premiums of reinsurers	Rs. 41.6 billion (\$946 million) (figure for GIC only in 2003/04)
Certification requirements for agents	Rs. 250 for renewal or issue of license 12 th grade standard passed 100 hours practical training

Social Protection and Microinsurance

The Employees' State Insurance Scheme (ESIS) founded by the federal government in 1948 and provided by a state corporation (Employees' State Insurance Corporation, ESIC) is another provider in the area of formal insurance, functioning as a social health insurance approach (Bhat/Mavalankar 2000; Ellis/Alam/Gupta 2000). ESIS is obligatory for employees of companies in certain industries wherever a certain number of employees are exceeded. The system is financed by contributions collected as a percentage of the gross wage. Each employee pays 1.75% of her or his wage in contributions, while the employer adds another 4.75%. The Indian states subsidise the system with general taxes. ESIS, which runs its own network of health care service providers, covers the areas of illness, motherhood, disability

and death from work accidents. With 8.5 million members, ESIS covers 33 million individuals (as of 31 March 2001, ESIC n.d.).

For central government employees and their dependants, health care services are provided through the Central Government Health Scheme (CGHS). The system was introduced in 1954 and is provided by the government for its employees (Gumber/Kulkarni 2000). Overall 4.5 million individuals are covered by the CGHS, which offers health care services through its own providers (Ellis/Alam/Gupta 2000). Both governmental schemes, ESIS and CGHS, are blamed for management weaknesses and inadequate and inefficient services.

Due to the low penetration of health insurance products in the low-income markets, micro health schemes have been emerging. Micro health insurance units aim at this market neglected by insurance companies with a different approach. Being non-profit and often community-based, microinsurers can work closer to the poor than their commercial counterparts. Usually, the micro schemes have their roots in self-help groups, microfinance institutions, NGOs or cooperative structures.

2. The Institution

2.1 History of the Institution

Yeshasvini Cooperative Farmers Health Care Trust is a charitable trust governing a health insurance scheme of the same name. The scheme was launched at the end of 2002 and became operational in June 2003. In October 2003, the Trust was officially registered as a charitable trust.

The Trust and its insurance scheme are based on the initiative of Dr. Devi Shetty. An expert in cardiac surgeries and chairman of Narayana Hrudayalaya Hospital in Bangalore, he was aware of the problems the rural population faces in accessing health care. He started a telemedicine programme in cooperation with Indian Space Research Organisation (IRSO). Through this programme, medical expertise is made accessible to people even in remote rural areas of Karnataka. He spread sophisticated surgical methods in many rural areas by connecting doctors and urban hospitals via satellite. Lack of proper infrastructure was deemed to be the root of the insufficient medical treatment many people experienced. This view was shared by many other experts.

However, field studies conducted on behalf of the hospital revealed something different: a number of hospitals throughout Karnataka experienced poor utilization rates, as low as 35%. This led to the conclusion that it was not improper health infrastructure, but insufficient financial means that hindered the poor people from curing their health problems. The costs of even minor health problems (e.g., appendix surgeries) make it very difficult for low-income groups to obtain the necessary care.

To address the problem of low purchasing power, the idea of health insurance covering critical surgeries evolved, and Dr. Shetty and his team developed the insurance model of Yeshasvini. Mr. A. Ramaswamy I.A.S., then Principal Secretary in the Department of Cooperation, Government of Karnataka, then gave concrete shape to Shetty's idea.

Yeshasvini's goal is to provide quality health care all over the state of Karnataka at affordable prices. The target group are relatively poor farmers organised in cooperative societies. An inexpensive insurance policy, affordable even for low-income groups, is only possible if there is a sufficiently big risk pool. Farmers pay a relatively small annual premium that allows them access to high-quality treatment including critical operations of the stomach, gall bladder, bones, eyes, uterus, brain and heart. To get a sufficient number of members, some of the bigger cooperative federations, e.g., Karnataka Milk Federation, were addressed. Others joined as well. To get in contact with these federations, the support from the Department of Cooperation was fruitful.

Within the first seven months, 5,000 members underwent all different kinds of surgeries and 23,500 farmers or family members had ambulatory consultations without paying an extra fee. Starting with 1.6 million of members in the beginning, the scheme already had more than 2 million members in 2004. Winning the cooperative sector, with its enormous coverage, was an important step to success.

Table 2.1 Insurance Organisation Basics

Issues	Observations
Legal structure	Registered Charitable Trust
Registration status	Registered in October 2003
Regulation status	Under charitable trust law
Start of corporate operations	2003
Start of microinsurance operations	June 2003
Core business	Insurance
Target market – core business	~ 8 million out of 19 million in cooperatives in Karnataka
Target market – insurance business	Same
Geographic area of operation	Karnataka
Development, marketing, or servicing policies with other institutions	Family Health Plan Limited as administrator Cooperative structure to distribute the product
Reinsurance provider, provider type	Desired but not available
Reinsurance type	No reinsurance; losses borne by government

Yeshasvini Trust is registered as a charitable trust eligible for tax exemptions. A charitable trust is an institution or fund registered under the Indian Trust Act of 1851, established to benefit a disadvantaged target group. A trust's objective needs to be consistent with the definition of the term "charitable purpose" which includes relief for the poor, education, medical relief and the advancement of any other object of general public interest. The income generated in the trust should not directly or indirectly be used for the benefit of the founder of the trust or other specified persons. Furthermore, the property should be held exclusively for charitable purposes.

Table 2.2 Insurance Organisation Basics - Trends

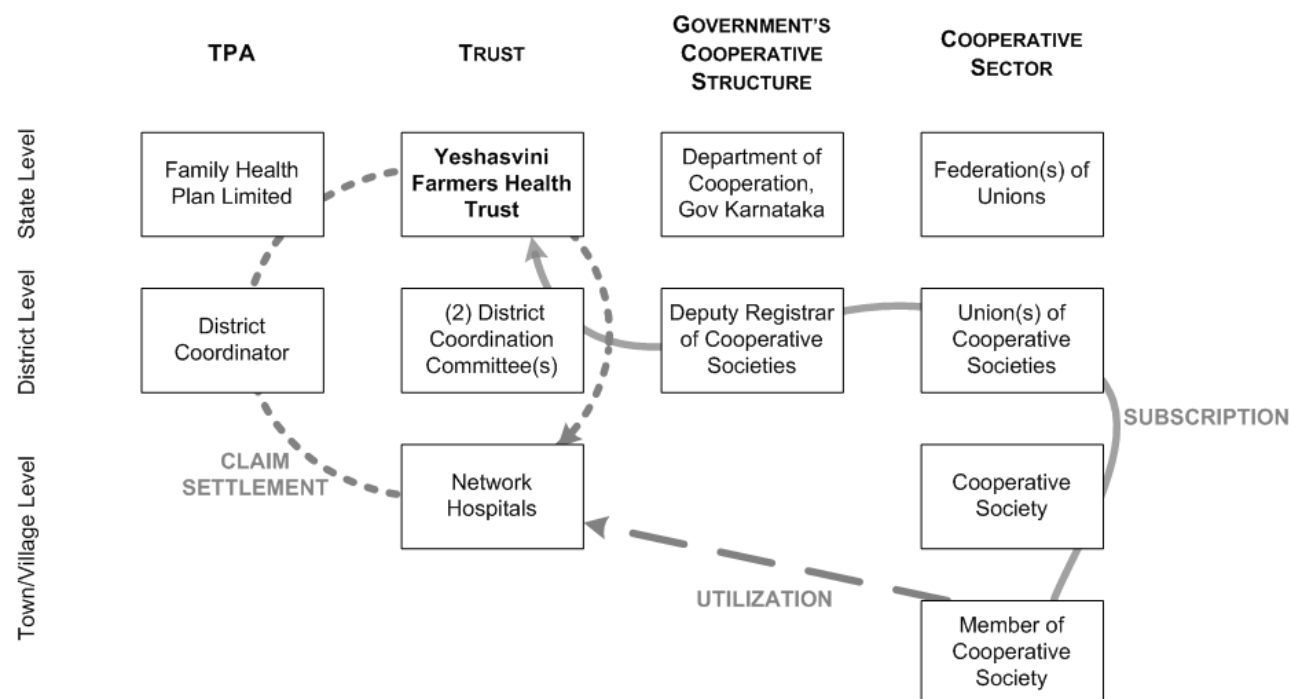
	2005	2004	2003
Total assets (US\$)	4,260,464	4,530,000	3,205,000
Annual budget (US\$)	4,645,000	3,795,000	3,205,000
Total capital	4,260,464	4,530,000	-
Number of branches	27*	15*	15*
Total number of microinsurance policyholders	1.45 million	2.2 million	1.6 million
Total number of microinsurance insured lives	1.45 million	2.2 million	1.6 million
Number of microinsurance staff	> 35	~25	~25
Number of policyholders / microinsurance staff	41,430	88,000	64,000
Microinsurance marketing costs (US\$)	Not accounted for		11,000

* The number given reflects the number of FHPL's district coordinators plus the office in Bangalore. But counting every secretary of a cooperative as a branch, the number increases to several hundred.

2.2 Organisational Development

Organisational Structure

To describe the organisational structure of Yeshasvini Cooperative Farmers Health Scheme, it is helpful to separate the full structure into four pillars: The Trust (in a narrow sense), the Third Party Administrator (TPA), the Government's Cooperative Structure and the Cooperative Sector (see Figure 2.1).

Figure 2.1 Organisational Structure of Yeshasvini Cooperative Farmers Health Scheme

The Trust

Yeshasvini Trust is the actual “owner” of its insurance scheme. It is registered as a charitable trust and governed by a board of trustees. This board consists of six persons from the Department of Cooperation, who are board members by designation, the Director of the Karnataka Health Department, and five nominated board members (mainly medical professionals). The board of the trust governs the whole scheme and is responsible for its further development, final decision on claims, reimbursing the claims, monitoring performance and listing new network hospitals. The TPA, Family Health Plan Limited (FHPL), representatives of the cooperative sector (federation level) and the network hospitals may attend the meetings as well (top line of the figure).

A cell of Yeshasvini has a weekly meeting at the office of the Registrar of Cooperative Societies to discuss operational issues. It is attended by the Additional Registrar Cooperative Society, the Chief Executive Officer of Yeshasvini Trust, the Joint Director of Karnataka Milk Federation and a representative of FHPL.

To assist in monitoring the scheme and the quality of care provided, the trust established **District Coordination Committees**. There are two kinds of committees in each district. One is a small weekly meeting of the Deputy Registrar of Cooperative Societies with the coordinator of FHPL. The second is a committee chaired by the District Collector. The Chief Executive Officer of the district attends this meeting as well as the Deputy Registrar of Cooperative Societies, the District Health Officer, the District Surgeon, the district coordinator of FHPL, representatives of the cooperative unions and the network hospitals. The committee also plays a coordinating role during the subscription/renewal phase as well as in the preparation of the decision for new network hospitals.

The **network hospitals** are the only designated health care providers in the scheme. Spread throughout Karnataka, they are mainly private hospitals, although some are charitable and a few have public stakeholders as well. As the network hospitals are usually big and with modern health facilities, they are mainly located in district capitals; some are highly specialised hospitals. The scheme started with 80 network hospitals and grew to more than 150. Driven by the intention to build a tighter network for the clients, some hospitals that do not entirely meet the high standard were included; it is expected that these hospitals can catch up in quality.

Box 2.1 Enrolling New Network Hospitals under the Scheme

All hospitals in Karnataka can apply to become a designated Network Hospital. They need to agree to the fixed price list and the administrative procedures. Although the price list is not very attractive for most surgeries, there are two economical reasons for hospitals to join:

- a) By joining the scheme, hospitals can reach higher utilisation of their facilities and reduce vacancies.
- b) Many of the hospitals treat the target group anyway, and have to give concessions that would earn them less than the Yeshasvini rates.

A hospital willing to join the Network has to apply to the District Collector, who is the head of government administration in the respective district. On behalf of the District Collector, who also chairs Yeshasvini's District Committee, the District Surgeon, the District Health Officer and the Deputy Registrar of Cooperative Societies inspect the hospital. Based on their report, the District Collector forwards a recommendation to FHPL. Their district coordinator also visits the hospital and submits a report in a prescribed format via FHPL to the Trust. The Board of the Trust takes the final decision on the application. In case of a positive decision, an agreement is signed with the hospital.

Third Party Administrator

Relatively new to the Indian insurance industry, TPAs are for-profit-companies that assume most of the administration of an insurance scheme in exchange for a commission. The TPA's main duty is to manage the contact between the client, the health care provider and the insurance scheme. Yeshasvini has hired **Family Health Plan Limited**, a TPA registered with IRDA, to administer its scheme: FHPL has experience with self-funded schemes as it administers two schemes for the police in Karnataka and Andhra Pradesh.

The tasks assigned to FHPL include:

- *Maintaining a register of the insured clients:* All members of cooperatives and their dependants can join the insurance scheme. The unions of the cooperative societies pass on the lists they receive from their member cooperatives to the Deputy Registrar of Cooperative Societies. He forwards them to Yeshasvini Trust and FHPL maintains a register of the clients for the trust.
- *Issuing ID cards:* Each client receives an ID card with a photo after subscribing to the scheme. In the scheme's first two years, the cards were valid for one year only; new cards were issued at time of renewal. To lower costs, the cards have been redesigned and can now be used for three years. They simply need to be renewed each year. FHPL issues and renews these cards.
- *Authorising treatment:* When a client seeks surgical treatment, FHPL must authorise the surgery. The hospital and client submit a photocopy of the client's ID card, a letter

from her/his cooperative society proving membership, receipt of premium payment (if possible) and a form filled by the doctor describing the surgery necessary. FHPL checks the documents and authorises the surgery.

- *Preparation of claim settlement including verification:* After a surgery the treating Network Hospital submits the final documents to FHPL and claims payment for the surgery. This claim form is accompanied by
 - A photocopy of the Yeshasvini ID card
 - A photocopy of the Yeshasvini receipt of premium payment
 - The (original) letter proving membership in the cooperative society
 - The (original) Pre-Authorisation issued by FHPL
 - Operating notes
 - Discharge summary
 - Final Bill
 - Investigation reports and prescriptions.
 FHPL checks these documents and prepares the claim's reimbursement for approval by the Board of the Trust.
- *Managing the funds:* FHPL manages the funds of the scheme, but does not hold them.
- *Monitoring the network hospitals and guide them:* It is the duty of FHPL to check the quality of the Network Hospitals and to make sure that all adhere to the rules set.
- *Prepare reports and statistics:* For every monthly meeting of the Board of the Trust, FHPL prepares statistics on the scheme's performance.

To fulfil these duties, FHPL maintains an office in Bangalore with an 8 person staff. It is this office's main responsibility to issue the pre-authorisation for the treatment and to process the claims. One of the persons is a medical doctor responsible for checking the medical aspects of a requested authorisation. Additionally, FHPL also employs one coordinator for each district. This person should:

- Visit the network hospitals in the district at least once a week and ensure that the terms and benefits of the scheme are being properly followed.
- Interact with the beneficiaries of the scheme undergoing surgical treatment for feedback.
- Inform the implementing agency about any non-conformance and follow-up on action taken.
- Collate data and statistics from network hospitals on a weekly basis.
- Attend the Yeshasvini District Committee meetings and follow the instructions of the Chairman.
- Send reports to the Medical Officer at FHPL Bangalore office on a daily basis and report any exceptional incidents.
- Visit the office of the Deputy Registrar of Cooperative Societies (DRCS) at least once a week
- Any other work entrusted by the FHPL office, Bangalore.

Government's Cooperative Structure

The Principal Secretary of the Karnataka Department for Cooperation chairs the board of the trust. The Department for Cooperation is actively involved in distributing the insurance

through the cooperative sector. The former Principal Secretary, Mr Ramaswamy (in office until August 2005), was very much in favour of developing the scheme and increasing the number of insured members. His successor, Dr. Kedar, is equally committed. He is the one who defines a target number of insured clients for each renewal period. This total target is broken down to each district and the unions in the districts. There is of course no penalty if the target is not reached; but one can assume that the District Registrars of Cooperative Societies will do their best to reach their targets. The government's support of the cooperative structure helps make the scheme as successful in reaching large numbers of insured.

Cooperative Sector

The cooperative sector is strong and well developed in India, with a long history. The Indian cooperative movement has its roots in the agricultural and allied sectors. By the end of the nineteenth century, "self-help" institutions spread among the poor rural population that often had to struggle with high debt burdens. Cooperative societies pooling meagre resources became popular, organised to protect against exploitation by unscrupulous moneylenders. Moreover, they turned out to be helpful in providing credit, marketing agricultural products and supplying inputs.¹²

In 1904, the Cooperative Societies Act enabled the formation of agricultural credit cooperatives in rural areas in India under government sponsorship. Governmental sponsorship and involvement are significant features of Indian cooperatives, distinguishing them from the Europe cooperative movement where people got organised to protect their interests without active government involvement.

After India became independent in 1947, cooperatives were assumed to have a great impact on reducing poverty and encouraging socio-economic growth. The Indian government included cooperatives in the Five Year Plans, making them a separate "segment" in the national economy. Moreover, the government actively supported and promoted cooperatives as they were seen as an important part of the new democracy. With the Indian Rural Credit Survey Committee Report in 1954, the influence of the government grew further. The government was recommended to participate in the capital structure of the cooperatives. This encouraged the government to treat cooperatives as state agencies rather than autonomous institutions.

Still, the cooperatives have made remarkable progress. They have entered several segments of the Indian economy during the last century, as there are credit-, banking-, production-, processing-, marketing-, housing-, warehousing-, irrigation-, transport-, and even industry-cooperatives.¹³ The cooperative movement has made significant progress in membership from 15 million members in 1950¹⁴ to about 200 million members in 1999, more than half of which were associated with an agricultural cooperative.¹⁵ The cooperative sector covers every village in India and 67% of all rural households are connected with cooperatives. India has a very large network of cooperatives, with some playing a role on a global level: India is a

¹² <http://pib.nic.in/feature/fe0299/f1202992.html>

¹³ <http://www.stmarys.ca/academic/commerce/economic/IAFEP/papers/Ramesha.pdf>

¹⁴ <http://pib.nic.in/feature/fe0299/f1202992.html>

¹⁵ <http://www.ncui.nic.in/stat.htm>

major international sugar and milk producer, and cooperatives are the largest milk and sugar producers in India.

However, the cooperative sector is far from being without problems. For a long time, members of various cooperatives had asked the central government for democratic reforms in their regulation, supervision and functioning. Intended to strengthen the sector, constant state intervention have in fact weakened the cooperative movement, as it is difficult for members to get ownership and take part in the decision making process. Especially at the primary level, many cooperatives cope with dormant membership, a lack of active participation, and low levels of professionalism.¹⁶ Still, an important role is attributed to cooperatives in trying to eradicate poverty and improve living conditions, especially in the rural areas.

The experience in Karnataka mirrors the development of the cooperative sector in India as a whole. The Karnataka cooperative movement is a publicly sponsored. The State Government has participated actively by providing capital, subsidies and loans to cooperative societies. Bringing social and economic changes in the life of members of the society is the main objective of the state's cooperative support structures.¹⁷ In Karnataka, almost 26,000 cooperatives are working well; but about 5,000 are defunct or liquidated. Almost every village in Karnataka is covered and about 78% of the adult population are somehow connected to a cooperative.

Cooperatives in Karnataka can be categorised into five sectors: credit, marketing, processing, milk (procuring, processing and marketing), and cooperative services. Currently, the majority of the population is engaged in the agricultural sector. The state's economy depends mainly on agriculture, so cooperative agricultural credits are particularly important. The milk procuring and processing sector is the largest in Karnataka, with more than 9,000 milk producers' cooperative societies in 2004.

Yeshasvini depends on this cooperative structure to provide information to members and to collect premiums. The members receive information about the scheme in their regular contact with the Secretary or President of their Cooperative Society. During the subscription period, they can join the scheme or renew their policy. The individual cooperative societies in turn receive their information from their unions. The link between the cooperative society and the union is maintained by the Extension Officer, a person employed by the union. He visits the cooperative societies in his area of responsibility on a regular basis. Informing the secretaries of the cooperative societies about insurance and collecting subscription lists and premiums is an additional task for him.

Insurance Knowledge and Experience of Managers

Knowledge about insurance varies very much in the scheme. Most people involved in the scheme in the network hospitals have a medical background; those in the cooperative sector are not very familiar with insurance; the TPA brings substantial knowledge about the insurance administration. But even in the TPA, not all are familiar with insurance through experience or education before joining the scheme. Persons appointed in the senior management of the trust to manage the insurance or to contribute from external positions, like

¹⁶ <http://www.stmarys.ca/academic/commerce/economic/IAFEP/papers/Ramesha.pdf>

¹⁷ <http://sahakaradarpana.kar.nic.in/>

the CEO for microinsurance operations at Dr. Shetty's Narayana Hrudayalaya hospital, Priti Jacob, have substantial knowledge about insurance. She has got her experience from working in the hospital's financial department.

FHPL employs 26 coordinators for the 27 districts of Karnataka and eight persons are employed in the Bangalore office. Except for the medical officer in the Bangalore office, who is a doctor, all persons employed have undergraduate degrees and received special training for their jobs in the insurance scheme.

There are different training modules for the FHPL staff and the staff of the network hospitals:

- FHPL's field coordinators receive a three-day training introducing them to the insurance scheme, the company (FHPL), and the tasks assigned to them. According to the TPA, these employees should come from the areas where they work and speak the local language. The training is conducted by FHPL.
- The administrative staff of the network hospitals receives training in Devi Shetty's Narayana Hrudayalaya hospital. The training is conducted by the staff of the hospital who are also responsible for the implementation of the scheme. The training provides information on the idea of the scheme and the administrative procedures with the TPA and the trust. It is intended to ensure smooth handling of all cases and proper treatment clients.

No special training was designed for the secretaries of the cooperative societies. They receive information from the extension officer during the implementation of the scheme.

Governance

Yeshasvini Trust is governed by a board of trustees. This board consists of 12 members and is chaired by the Principal Secretary of the Department for Cooperation. Five other employees of the Karnataka Department of Cooperation are members of the board. Five board members represent the network hospitals and are well-known health professionals, like Dr. Devi Shetty. In November 2005, the Director of the Health Department was appointed as the 12th trustee. Representatives of the TPA, Family Health Plan Limited, and further network hospitals can join the meetings as guests.

2.3 Resources and External Relationships

The scheme is designed as a self-funded insurance scheme. It is therefore financed mainly through contributions of the members, but has relied on additional subsidies until now. In the first two years of operation, the clients paid Rs. 60 per person as a premium. The government of Karnataka complemented the premium collected in the first year with additional Rs. 30 per person. Although this subsidy was stopped in the second year, additional funding from the Government was requested and granted. Altogether, the government provided Rs 45,000,000 (\$1,022,727) in the first year and Rs. 35,000,000 (\$795,454) in the second year.

It is estimated that an annual contribution of Rs. 100 (\$2.3) per person would lead to an increased financial stability in the third year (2005/06). A premium of Rs. 120 (\$2.7) is now

charged for adults, while unmarried children younger than 18 years pay Rs. 60 (\$1.4). The scheme expects that this should lead to an average premium of Rs. 100 in this third year. Nevertheless, the state will provide a subsidy of Rs. 50,000,000 (\$1,136,364) to the scheme in the third year.

Karnataka's Department of Cooperation is a critical stakeholder. The department got involved in the design phase when Dr. Shetty was looking for a strong partner to help reach the rural population. Now, the full structure of this department and its access to further government resources is utilised by the scheme.

As discussed above, since the cooperatives are somewhat dependent on the government, the Department of Cooperation can influence their involvement. Consequently, it is comparatively easy to convince the members to join the scheme. Members can simply deduct the insurance premium from their business income generated with the cooperative society. To a certain extent, the flow of information is also secured through this institutionalised structure. The cooperatives are Yeshasvini's key to large numbers of insured.

The Department of Cooperation can access further governmental structures for the benefit of the scheme. On the district level, the District Collector, the head of the district administration, is involved in the implementation of the scheme as well. He chairs Yeshasvini's coordination committee in his district. The District Health Officer and the District Surgeon, together with the district representative of the Department of Cooperation, inspect hospitals applying to be included into the network. Through the enthusiastic involvement of the Government, the Yeshasvini is often regarded as a government scheme. And indeed the government has "taken over" the scheme to a certain extent due to the important role it plays.

To administer the scheme, Yeshasvini appointed Family Health Plan Limited. This profit-oriented TPA was founded by the Apollo Hospitals Group – one of the biggest hospital groups in India – about a decade ago and is now the largest agency in the field of health insurance administration. FHPL strongly believes in self-funded schemes and intends to extend its operation in this field. The focus is on low and middle-income groups.

Availability of quality health care is crucial for successful health insurance. Yeshasvini Trust decided to align with a number of mainly private hospitals, which have a better reputation than the public facilities. Many studies in India revealed that even poor people prefer private facilities. Network hospitals have to fulfil certain quality criteria, and those that meet the standards are often located in the district capitals. This requires some clients to travel about one hundred kilometres to reach a designated facility—the average distance is estimated to be around 40 km. To increase access, some hospitals in *taluk* capitals are now included. This is a problematic issue for the scheme, as they have not reached the quality level expected. Today, more than 150 hospitals are designated facilities.

2.4 Risk Management Products Offered by the Institution

Yeshasvini Trust only offers the insurance scheme described in this case study. Some of the network hospitals implement their own programmes for poor segments of the population, which might help to cope with risks not covered under the Yeshasvini scheme. They were not designed to complement the Yeshasvini scheme, but were in existence before.

2.5 Profit Allocation, Investment of Reserves and Reinsurance

The funds collected remain with the trust and are kept for the subsequent years in case of future deficits. The premiums collected, as well as potential surpluses, are put in a bank account until they are used for reimbursement. There is no special policy on the investment of reserves yet. Nevertheless, in the first year of operation Yeshasvini generated interest of about Rs. 3,700,000, which represents 3.8% of the premium collected or 2.6% of total income.

So far, there is no reinsurance available for this kind of scheme in India. The scheme management would welcome a reinsurance facility, which would enable them to handle excess claims while keeping their independence and ownership. Being able to keep the ownership is one of the main concerns of the scheme. This is the reason why offers from insurance companies to take over the insurance operations have been refused.

3. Members

Table 3.1 Client Information Table

Issues	Observations
Intended target groups/clients	Members of cooperative societies and their families
Actual clients and reasons if deviation from intended market	Members of cooperative societies and their families
Exclusions of specific groups	Non-members of cooperative societies and their families
General economic situation of clients	Low-income but not very poor
Key economic activities of clients	Agricultural sector
% of clients working in the informal economy	
Social characteristics of clients	Mainly farmers (agriculture and cattle)
Geographic characteristics	All over Karnataka
Nature of membership	Individual members of the cooperative societies and their families
Methods of recruitment of clients	Through cooperative structure

The insurance scheme exclusively targets members of cooperative societies and their dependents in Karnataka. In July 2005, there were 31,000 registered cooperative societies in Karnataka of which about 26,000 are classified as functioning. They are active in fields such as (agricultural) credit, cattle breeding and dairy, sericulture, textiles, sugar planting and processing.

The very majority of the target population works in the agricultural sector. Most of them belong to the middle class of a village (not society as a whole!); they, for instance, own a small piece of land or a few cows. An average income (profit) of a dairy household can be estimated at Rs. 1500 per month; and some earn additional income by pursuing other activities. Some members are much wealthier, but joined the scheme to enjoy the benefits initially designed to help the poor. As they are members of a cooperative as well, there is no mechanism to prevent them from joining.

The target population is spread all over Karnataka, although not all districts are equally well developed. Infrastructure and services available are better around bigger cities. Some of the clients live in more remote areas and have to travel long distances to reach a network hospital.

Health is an important risk factor for poor households. Without insurance, coping strategies include savings, borrowing money from neighbours or moneylenders, and selling assets. Many expect that this insurance will help them to cope better with health problems. But the coverage does not respond to the most frequent health problems, but rather to the most frequent surgeries.

Familiarity with insurance prior to enrolment seems to be virtually not existent. Still many – probably most – insured members are not aware of insurance mechanisms and know only a

few details about benefits, exclusions and claiming procedures. In a household survey¹⁸ conducted by the project “Strengthening Micro Health Insurance Units for the Poor in India”, 55% of the interviewed insured households (N=364) did not even have a rough idea what insurance is or how it functions (uninsured (N=354): 71%). Hence, dissatisfaction often arises when clients need treatment that is not covered, but which they expected to be.

In the last two years, awareness is slowly spreading through word of mouth from beneficiaries. But negative reports about rejected claims (for services not covered) as well as long waiting periods for authorisation can also be heard.

¹⁸ The survey, conducted in June & July 2005, was funded by the European Union with additional support kindly granted by Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ).

4. The Product

Table 4.1 Product Details

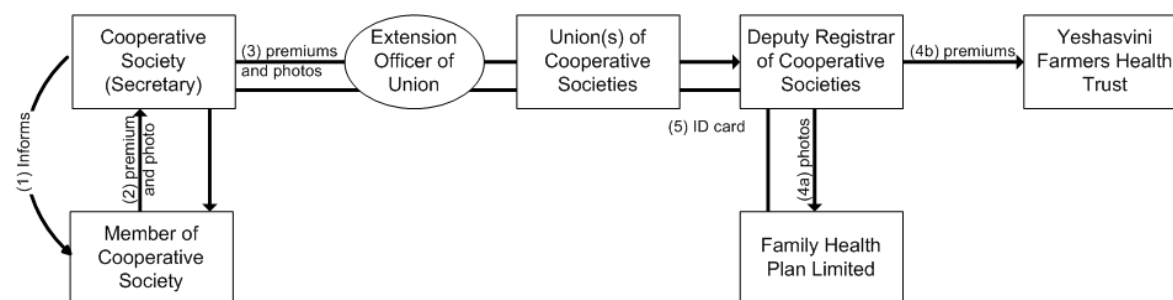
	Product Features and Policies
Microinsurance Type	Self-funded scheme
Group or individual product	Individual/household level
Term	One year
Eligibility requirements	Member of cooperative society and their family (spouse & children)
Renewal requirements	Member of cooperative society and their family (spouse & children)
Rejection rate	No such case was reported
Voluntary or compulsory	It is designed as a voluntary scheme and clients report to have joined voluntarily. The secretary of the respective cooperative society advises members to join because it is good for their health.
Product coverage (benefits)	(Predefined) Surgeries and all costs connected for common ward OPD is free but drugs prescribed in OPD have to be purchased Only listed hospitals can be used
Key exclusions	All other surgeries not defined in a list; inpatient treatment/hospitalisation without surgery.
Pricing – premiums	Year 1: Rs. 60 from each insured client and Rs 30 as government subsidy Year 2: Rs. 60 from each insured client ¹⁹ Year 3: Rs. 120 per person (some cooperative societies and their unions pay Rs 10 each from their profits as subsidy per insured person)
Pricing – co-payments and deductibles	Diagnostic tests/investigations at discounted rates

4.1 Partners and Distribution Channels

Yeshasvini Trust partners with the Karnataka Department for Cooperation for the distribution of the product. The administration of the scheme is outsourced to the TPA ‘Family Health Plan Limited’. A network of accredited hospitals provides the health services in the scheme; some of these hospitals are affiliated with Narayana Hrudayalaya hospital in Bangalore.

Yeshasvini’s insurance is distributed through the cooperative structure in Karnataka. The structure is strong and reaches out to about 19 million members mainly in rural Karnataka. Only members of cooperative societies, their spouses and children can join. This distribution process is shown in Figure 3.1.

¹⁹ The government subsidy given in the second year of operation was on overall subsidy to the scheme and not related to the premiums.

Figure 4.1 Product Distribution Process

The cooperative structure allows for the flow of information and premiums between the insurance scheme and the clients. The Department of Cooperation uses this structure to quickly reach a many members and defines membership targets before each renewal/subscription phase. A proportion of this target is assigned to the districts and their cooperative societies. The secretaries of the cooperatives use different methods to achieve the targets: some try to convince their members by giving extensive explanations, others simply randomly define who joins, or even subscribe all members. The latter method constitutes a serious problem and threatens the reputation of the scheme.

In the favourable procedure, the cooperative secretary informs members about the scheme (point (1) in Figure 4.1). This normally happens during the three month subscription phase in the day-to-day contact between the member and the secretary of the cooperative. Members who decide to enrol pay their premium and hand over a photo to the secretary (2); in exchange, they receive a receipt. As many of the prospective members do not have photos, some secretaries organise a photographer to visit the village (Rs. 30 for four photos).

Cooperative society and the union are in contact through the union's Extension Officer; he regularly visits the cooperative and forwards premiums and photos of the subscribers to the Deputy Registrar of Cooperative Societies (3). The registrar's office transfers the premiums to Yeshasvini's bank account (4b) and hands over the photos to FHPL (4a). FHPL registers all clients with a management software and issues a photo ID card that is sent to the client (5). It takes about three months before clients receive their ID cards; if they fall ill in the meantime, they use their receipt of payment and a letter of the cooperative to claim benefits as evidence of enrolment.

Rejections are only reported when members apply outside the period of subscription or if applicants are not member of any cooperative society. The clients play virtually no role in underwriting. The secretary of the cooperative society bears the main responsibility.

Summary and Issues

This distribution channel has proven to be extremely effective in reaching a huge membership quickly. This is especially true because of the targets set by the Department of Cooperation. If secretaries react to these targets by enrolling members with pressure or make enrolment compulsory, the long-term effectiveness is jeopardised, as there may be dissatisfaction among clients. The practice of some secretaries to enrol members on a compulsory basis is a double-edged sword for the insurance scheme: as a self-funded scheme, it relies on large membership to reach financial stability. Where the premium comes from is

not important at this point. On the other hand, this practice is likely to damage the scheme's reputation as clients become dissatisfied. The board of the trust acknowledges both sides of the coin and plans to increase flow of information. It is expected that better information will make all clients join voluntarily.

Following the subscription phase, an ID card for each client has to be issued. Given the volumes of clients, some errors are unavoidable, i.e., some cards are issued containing wrong information. In such cases, new cards have to be issued and the client needs to wait a little longer for her/his card.

The distribution channel can be very effective, as permanent contact points for information exist between the client and the secretary. If clients receive proper and repeated training they could act as communicator for the scheme and inform others about its benefits. The increasing positive experience would quickly make this distribution channel all the more effective. But at the moment the flow of information to the secretaries, as well as to the clients seems to be insufficient.

4.2 Benefits

The assumption underpinning the benefit package, in the way it is designed now, is that poor households cannot afford surgeries that are often life saving. Those who do choose to have the necessary surgery are often impoverished by its costs. However, as only few illnesses require surgeries, a large number of households joining together in an insurance scheme can make surgeries accessible for those who need it.

The scheme covers more than 1,600 surgeries. The Trust and the health care providers have fixed a price for each surgery, including nearly all connected costs. A client requiring one of these surgeries can approach a network hospital—although some special surgeries require specialised hospitals. Admission charges, bed charges in a common ward, nursing charges, anaesthesia charges, O.T. charges, surgeon's charges are all covered, as well as the costs of consumables and medicines during and after the operative period, post-operative charges and surgery related investigations. Additionally, free OPD consultations are given to clients as well as investigations at a special rate of about 70% of the usual costs (if not connected to surgery). Drugs prescribed in OPD need to be purchased.

The maximum coverage for a person per year is Rs. 200,000 (\$4,545). This is sufficient for two of the most expensive operations and some smaller ones. The price for surgery paid to a network hospital is about 30% below the average price charged. In case of complications, the treating hospital has to bear the additional cost; the scheme does not reimburse for it. It seems to be the case that for some hospitals, the prices for some surgeries are more attractive than for others. Some hospital managers also claim that not all prices have been discounted with the same percentage.

The scheme does not cover inpatient admission without surgery. Further exclusions are:

- Transplants
- Burn cases
- Malignancies – Chemotherapy
- Cosmetic Surgery
- Road Traffic Accidents
- Medico Legal Cases
- Angioplasty
- Autoimmune diseases
- Vaccination
- Normal deliveries
- Dental surgery
- Incision and Drainage
- Implants including valves, grafts, mesh, nails, screws
- Skin grafting for wounds
- Joint replacement surgeries
- Vitamins, tonic and sanitary items
- Follow-up treatment
- Spectacles, hearing aids
- Dialysis
- Ambulance services
- Food
- Artificial limb
- Telephone charges
- Biopsies
- Deviated nasal septum
- Kidney transplants
- Any other expenditure not related to hospitalisation with surgery

The list of exclusions indicates that a considerable risk for high health costs is still not covered and needs to be borne by the patient.

Special Needs of Women and Children

Although some 78 percent of the adult population in Karnataka is somehow connected to a cooperative society, most cooperative members are men. Yeshasvini Trust covers the members of the cooperative societies and is open for their families as well. About 60% of Yeshasvini's members are male and only 40% female. As the women themselves are not usually the members of the cooperatives, it seems more difficult for them to get insured in Yeshasvini: the member is the first one to enter the scheme and coverage of the family may come later. Changing this, e.g., by introducing a reduced fee when the whole household is covered, could increase women's access to insurance and reduce adverse selection at the same time. A number of women-specific surgeries are covered. Normal delivery is not covered, but caesarean – if medically required – is covered.

Summary and Issues

Yeshasvini decided to focus its benefit package on one relatively expensive element in the health care spending of the clients: surgeries. It offers a comprehensive protection from these (very) high costs events and helps to substantially reduce the risk borne by the households. However, surgeries are relatively seldom and so many households feel that the most frequent costs are not covered. In the perception of the households, free OPD is a step in the right direction; but this is only relevant for households living relatively near to a network hospital as otherwise the costs of travel (and opportunity costs due to loss of wages) quickly exceed the amount saved. Coverage for hospitalisation without surgery e.g., following accidents and drugs are demanded.

4.3 Premium Calculation

Based on the experience gathered in Dr. Shetty's Narayana Hrudayalaya hospital, it was estimated that life saving operations cost Rs. 10,000 (\$227) on average. Figures from the west indicate that only 1 to 2% of the population require major surgeries. Fixing a premium

of Rs. 90 was obviously done hoping that the actual number of clients requiring surgery would be at the very bottom end of the western experience. Large numbers of insured were needed to ensure sustainability of the scheme.

The premium for the first year was fixed at Rs. 90, of which Rs 30 were subsidised by the government and Rs. 60 charged to the client. Due to fewer claims than expected in year one, the premium charged to the clients was kept at Rs. 60 and no additional government subsidy complemented the premium (although the government subsidised the scheme when the claims exceeded the premium collected in that year).

Based on the experience of the previous two years, an average premium of Rs. 100 is expected to be sufficient for sustainable operations of the scheme. The premium for adult members is fixed at Rs. 120; children can insure for half the price. The reduced rate for children was introduced to increase the number of children covered in the scheme.

Some cooperative societies decided to subsidise the premium of their members with Rs. 10 and some unions subsidise the same amount. Many members who have not experienced the benefits of the scheme refuse to enrol again due to the increase in premium. Others still feel that get value for their money, although some do not know details about the scheme.

Operational Costs

The administration of the scheme is outsourced to FHPL. For this, FHPL and Yeshasvini Trust negotiated payment of Rs. 7,000,000 (\$159,000) in Year 1 and Rs. 4,000,000 (\$90,900) in Year 2 and 3 to FHPL.

Dr. Shetty's Narayana Hrudayalaya hospital also contributes to the scheme by conducting training for network hospitals and engaging in public relations activities. The exact amount contributed is not known. Also, all the other hospitals contribute to the administration of the scheme by running a Yeshasvini counter in their hospitals for servicing insured members. Furthermore, the contribution of the cooperative sector is not accounted for, but is huge in distributing and servicing the product.

The photo ID cards used in the scheme cost around Rs. 1.75 each to produce. Yeshasvini Trust plans to sell the backside of the card for advertisements to refinance a considerable proportion of the production costs.

The total operations cost can be estimate to be at Rs. 5 per insured (including ID card). But a huge amount of the operations costs are hidden costs as they are borne by the network hospitals and the bulk by the cooperative sector.

Subsidies and Grants

Although Yeshasvini Trust is designed as a self-funded scheme, the government insisted on subsidising the premium to the tune of Rs. 45,000,000 (\$1,022,000) in Year 1. In the second year, the government budgeted a subsidy for the scheme as well and Rs. 35,000,000 (\$795,000) was in fact used. For the third year, a subsidy of Rs. 40,000,000 is agreed on.

The supporting administrative structure of the government and the cooperative societies is also provided for free.

Summary and Issues

The scheme was initially designed to be self-sustaining rather quickly and not rely on any subsidy. This goal has not been achieved yet. Tackling adverse selection by giving incentives to insure the whole household might help achieve this goal.

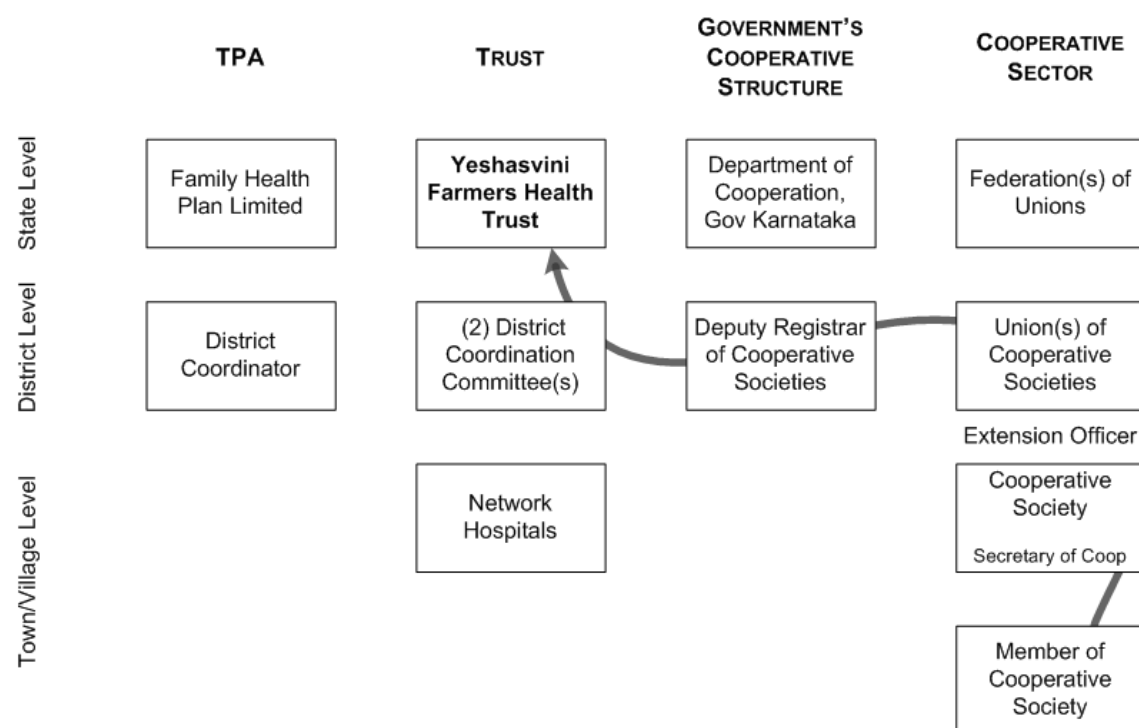
Additional to the visible government subsidies, a major contribution is made as hidden subsidies, especially by the cooperative sector. Without the contribution of the cooperative structure and the contribution of the network hospitals the scheme is unlikely to reach financial viability soon.

4.4 Premium Collection

All households enrolled in the scheme are in a business relationship with a cooperative society. By selling goods to the cooperative society, they generate a significant proportion of their income. This income is used to pay for the premium.

The process of premium collection is integrated in the members' business relationship with their cooperative society (as shown in Figure 2.2). During the subscription period, the secretary of the cooperative collects the premium from the member and issues a receipt. In case members cannot pay the amount in cash, it will be deducted from the income they gain from selling goods to the cooperative society (see Box 4.1).

Figure 4.2 Premium Collection



At the end of the collection process the secretary of the cooperative (physically) hands over the premium collected to the Extension Officer, an employee of the union to which the cooperative society belongs. The premium of members who did not pay in cash is debited on the cooperative societies account at the union and deducted from payments to the society. The premium of all unions and cooperatives in a district are collected at a bank account of the office of the Deputy Registrar of Cooperative Societies who then places the money in Yeshasvini's bank account.

Box 4.1 Paying in Milk

Mangsandra, a little village with about 1,000 inhabitants, is located in Kolar district near Bangalore. Dairy is an important economic activity in Mangsandra. About 200 families are members of the Mangsandra Cooperative Milk Society. For seven years, Krishnamoti has been the society's secretary. Since 2003, he is also responsible for providing information about Yeshasvini's health insurance, enrolling members and collecting their premium. He is not very clear on all of the scheme's details, but the milk union in Kolar provided him with information and a comprehensive booklet. He tries to convince people to join the scheme because he thinks that it will be beneficial for their health. In the first year, 96 persons joined. In the second year, 230 members and their dependants enrolled; mostly from the middle class of the village. Now, since the premium was increased to 120 Rupees, 25 refused to renew their policy. He can understand their reaction, as he is also not happy with the increase.

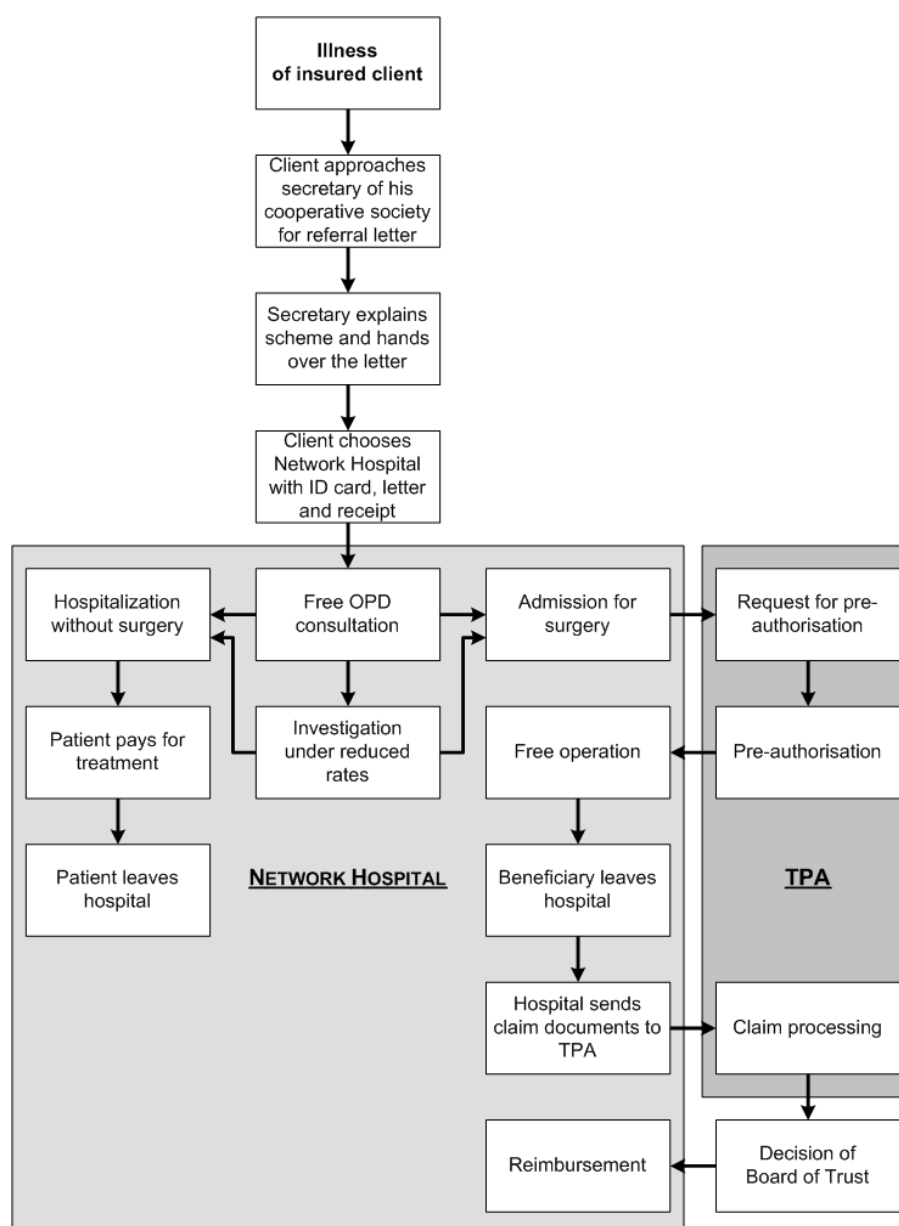
Krishnamoti reports that it is difficult to pay the premium for a family at one point in time. But the Milk Union developed a solution for this problem. Every morning the cooperative members bring milk to the society and Krishnamoti records each member's contribution in his books. Every day a lorry collects the society's milk and transports it to the union for processing and marketing. On a monthly basis, the union pays the society for the milk received. It is payday for the members of the society as well. Krishnamoti pays them according to the amount of milk they delivered during the month.

When members subscribe to Yeshasvini or renew their policy, they can ask to have their premium deducted from the income the society pays them. When Krishnamoti hands over the list of enrollees to his union, he informs the Extension Officer how many opted for the premium deduction. The milk union then advances the money when handing it over to the office of the Deputy Registrar of Cooperative Societies. The advance payment is then deducted from the union's monthly payment to the society, which in turn deducts it from the share of the respective member. If members decide to enrol their dependants in the scheme as well, the society only deducts the amount for one person each month and so enables the member indirectly to pay in instalments – in instalments of milk.

4.5 Claims Management

Claims Settlement Process

In case of illness, an insured client needs to prove membership in a cooperative society before approaching a network hospital. For this purpose, the client contacts the secretary of the cooperative society for a referral letter. This referral letter is usually counter-checked and signed by the deputy manager of the responsible union and the assistant registrar of cooperative societies, both located in the capital of the district. This documentation is especially important if the member falls ill when new ID-cards are being produced. Some request a letter from the Department for Cooperation to get faster admission.

Figure 4.3 Claim Settlement Process

(Modified from Kuruvilla/Liu/Jacob *unpublished*)

With this letter, the photo ID-card and the receipt of having paid the last premium, the client chooses a network hospital for treatment where he or she registers at a special counter or with a designated person. Some Yeshasvini members claim that they were not treated in a friendly manner by the hospital's staff after showing their membership card.

The patient receives free OPD consultation and – if necessary – investigations under reduced rates. These investigations are free if the patient is admitted for surgery. If the patient needs to be admitted without surgery, he or she must pay for the hospitalisation. In case surgery is needed, pre-authorisation is requested from the TPA. A photocopy of the member's ID card, the receipt and the referral letter are sent along with the pre-authorisation form filled by the

treating doctor. Receiving authorisation from the TPA takes at least four to five days, and sometimes longer. Sometimes the documents submitted by the hospital are incomplete, which delays authorisation further. Pre-authorisations for surgeries in emergencies ought to be given within a day orally by the medical officer of FHPL; the documents should then be sent by courier. If in emergency cases the request for authorisation is pending, some hospitals charge the patients and reimburse them after receiving authorisation.

With the authorisation obtained, the surgery is conducted free of costs for the patient. The rate for the surgery is fixed. After discharge the hospital submits the claim documents to FHPL, including further photocopies of the Yeshasvini ID card and the receipt, the original referral letter from the cooperative society, the pre-authorisation form issued by FHPL, the operating notes, the discharge summary, the final bill and investigation reports as well as prescriptions. FHPL then scrutinises the documents and settles the claim. If documents are missing, the hospital is requested to provide them before claim processing can be finalised. Processed claims are forwarded to the monthly meeting of the Board of the Trust for final approval. After approval, the claim is paid to the hospital.

Reimbursing claims can take about three months. It can take more than a month from submission of the claim to FHPL, scrutinising it, to finally presenting it at the monthly board meeting. Transfer of the money can take about a month as well. While this is no problem for large, financially solvent hospitals, it troubles some smaller, charitable ones.

Common Reasons for Delays & Rejection

Reasons for delay in claim settlement and pre-authorisation can be found on the side of the network hospitals as well as the TPA. Documents missing or improperly filled are the main reason for delay in pre-authorisation and claim settlement. When documents submitted to FHPL are insufficient, the hospital is requested to send a corrected set of documents. This can take time especially when the client needs to get involved (e.g., for providing a referral letter). These referral letters are especially important when ID cards are not yet issued. The longer it takes to issue ID cards for all members, the more likely delays in claim settlement. Currently, it takes up to three months from subscription until the clients receive their cards.

A further, technical problem, recently led to delay in pre-authorisation. FHPL's Bangalore office concerned with issuing pre-authorisations is equipped with a fax machine. This fax machine is offline for some months now so that all the documents required for pre-authorisation need to be sent by post or courier. This is especially unfavourable for hospitals and clients far away from Bangalore.

Claims get rejected of course if the surgery requested is not covered under the scheme. Some clients are not properly aware how to claim benefits; for example, they may present their ID card only after surgery. As it is necessary in the Yeshasvini scheme to receive pre-authorisation, these claims are rejected.

Other Issues with Claims

The knowledge about the claim procedure is limited among the clients. Some are unaware about the network hospitals and address the wrong hospital. Others forget to show their ID

card before seeking treatment and do not receive any benefits. This leads to dissatisfaction that spreads at least as fast among the target group as the experience of satisfied members.

The long time needed for authorising treatment is another problem. Many clients spend a lot of money travelling to the hospital. Going the distance twice constitutes a heavy burden. Decentralising the pre-authorisation to district level could speed up the process.

A further issue raised by some clients is that they feel hospitals overcharge Yeshasvini clients for services not fully covered (like investigations) and then give a discount on the overrated price to earn the money they would earn from non-insured persons. Some hospitals state that the prices defined for surgeries are too low and do not cover the costs.

Table 4.2 Claims Settlement Details

Issues	Observations
Parties involved in claims settlement	Network hospital, TPA, Trust
Documents are required for claims submission	• photocopy of the Yeshasvini ID card • photocopy of the receipt of premium payment • original referral letter from the cooperative society • pre-authorisation form issued by FHPL • operating notes • discharge summary and final bill • investigation reports • prescriptions
Claims payment method	Directly to hospital
Time from insured event to submission	20 days
Time to pass through any intermediaries	3 days
Time from submission to payment	60 days
Claims rejection rate	Not known

4.6 Risk Management and Controls

Moral Hazard

Yeshasvini's insurance product reimburses for surgeries only. This makes moral hazard on clients' side unlikely as one can assume that few seek surgery for the sake of surgery. Provider-driven moral hazard is also unlikely as most predefined prices are not lucrative for hospitals. Nevertheless, some surgeries are profit generating (or at least loss reducing) for certain hospitals. If a hospital charges the patient additionally, the situation of provider-driven moral hazard becomes more imaginable. By randomly interviewing patients, FHPL's district coordinators reduce the likelihood that health care providers are charging unjustified fees.

Adverse Selection

In every insurance scheme, the incentive to join for those who expect health problems is high – the same is true with Yeshasvini Trust. There is no screening mechanism at the time of subscription and no pre-existing illness is excluded. The scheme is restricted to members of cooperative societies and their dependants. The dependents to be insured are chosen by the

household and here adverse selection is likely to happen as well. This problem could be tackled by offering a reduced rate in case the whole household joins.

Fraud

The mechanisms to avoid fraud are not well developed in Yeshasvini's scheme. When a hospital requests pre-authorisation, the TPA cannot control very well whether the surgery requested for a patient is indeed the surgery conducted. Normally, FHPL's district coordinator should visit the her or his hospitals regularly, but that arrangement is not yet working properly in every district. Even with the visits, it might be easy for a hospital doctor to sell this medically untrained person an X for a Y. Due to insufficient ex-post verification, hospitals could claim more expensive operations than they actually did.

Another potential source of fraud is with the members. It is difficult to control whether the person seeking treatment and presenting a Yeshasvini membership card is indeed the person insured. Identifying the person in the photo has to be done by the hospital; but for the hospital staff, it does not matter too much whether the person seeking care is in fact insured. Therefore the TPA and the Trust are considering requiring a photo of the person seeking care to be taken in the hospital. This photo would be submitted to the TPA when requesting authorisation and the TPA could then compare it with the photo of the insured person kept in an archive. This is intended to prevent free riding in the scheme.

Cost Escalation

The danger of cost escalation is limited as prices for surgeries are fixed and the amount of benefits restricted to Rs. 200,000 per person and year. Costs can only escalate through increased utilisation. An increase in utilisation is likely to happen when clients are better aware of the functioning of the scheme.

Covariant Risk

Yeshasvini's area of operation is the whole of Karnataka, which minimises the danger of covariant risks.

Others

The insurance scheme is designed to help the rural poor access expensive surgeries that they otherwise could not afford. On this basis, the hospitals agreed on a list of fixed prices that are about 30% below the average price for these operations. However, there is no mechanism to ensure that only poor segments of the population join, as the scheme is open for all cooperative members. Some affluent members of the society make use of the reduced rates under the scheme and subscribe as well. This happens rarely, but leads to some frustration from the provider ("they drive in with a Mercedes and show their Yeshasvini card").

4.7 Marketing

For an insurance scheme of the size of Yeshasvini's, surprisingly little effort has been put in marketing and education of clients. The budget spent for marketing in the first year was Rs. 500,000 (\$11,364). In the subsequent years, many marketing activities were organised and

financed by Narayana Hrudayalaya hospital, which makes it difficult to give an exact budget figure.

The main marketing channel used is the cooperative structure; but the information given through it does not reach the (potential) client very well. To some extent, it has a “Chinese Whisper” character. Only few are aware about details of the scheme or the functioning of insurance. To provide solid information to the key marketing persons – the secretaries of the cooperatives – a handbook was developed and distributed. This handbook contains details about the procedures in the scheme and a list of all 1,600 surgeries covered. It is more like a small reference book rather than a helpful marketing tool.

An additional information flyer designed by the scheme is more appropriate for marketing (see Appendix 2). Published by Narayana Hrudayalaya hospital and the Department of Cooperation, it discusses the insurance in a well-structured way and is nicely designed.

To intensify the marketing activities, an advertisement-spot for TV has recently been produced and will be broadcasted soon. It tells the story of a farmer collapsing in his field. Unlike his fellows, who advise him not to go to hospital due high costs related, he can get proper treatment, as he is member of Yeshasvini. Back from hospital, the farmer explains to his colleagues that membership with Yeshasvini made his treatment free of costs.

Yeshasvini Trust is a well-known insurance “brand” among those who are not members of the scheme. Newspapers and media report about the scheme regularly. Events like press conferences are organised by Dr. Shetty’s Narayana Hrudayalaya hospital. However, in the public, it is often regarded as a government scheme. Little is known about the details of the scheme; few of the clients know about the features of the scheme or the concept of insurance. The marketing channels do not seem to be utilized very effectively.

4.8 Customer Satisfaction

Many clients are not aware of what benefits are covered and how to claim these benefits. Dissatisfaction arises when they are told at a hospital that certain services are not covered. A further source of dissatisfaction is the long waiting period until pre-authorisation is given. Some clients travel long distances and cannot afford to go back before the surgery.

It is easy to organise the renewal process through the cooperative structure. As positive experience about benefits received spreads by word-of-mouth, the motivation of the clients to renew their policy is likely to increase. However, negative experiences – about expected benefits not received, waiting periods and unfriendly treatment from hospital staff – spreads as well. Some refuse to join because of these problems. In the last renewal period, some also dropped out because of the increased premium; they did not feel that they get good value for their money.

5. The Results

5.1 Management Information Systems

Yeshasvini Trust is keen on monitoring the performance of the scheme by making use of structured information. Therefore, a mechanism for the flow of information is currently being established. This information is mainly collected through FHPL. Their district coordinators ought to visit the network hospitals in their respective area weekly and obtain information on patients treated from there. They forward the information to FHPL's Bangalore office where statistics are prepared for the monthly meetings of the Board of the Trust.

5.2 Operational Results

Yeshasvini's operational performance has been extremely successful. By linking up with the cooperative sector, the scheme was able to start with 1.6 million members right away. This number increased to 2.2 million in the second year but dropped to 1.45 million in 2005, the third year of operation due to the increased premium. This, (still) incredible success in terms of membership, is partly due to slight pressure put on some cooperatives to enrol a certain number of members. Some reacted by arbitrarily enrolling members without seriously consulting them. However, a big proportion of the members enrolled voluntarily; some secretaries report that they have never heard about the target numbers to be reached.

The scheme makes surgery available to patients who probably would not be able to finance it otherwise. The average price for surgeries conducted in the first year of the scheme's operation amounted to Rs. 11,650 (\$265). One can assume that many of the households could not have financed such a surgery or would have been indebted by it. Additionally, more than 30,000 free OPD treatments were given in the first year as well.

5.3 Financial Results

In the first two years of the scheme, claims exceeded the amount of premium collected from the members and the scheme relied on subsidies from the government. With these subsidies, a positive balance was kept and transferred to the subsequent year. Yeshasvini Trust expects to get closer to financial sustainability by increasing in premium in 2005 from Rs. 60 to Rs. 120 per adult. Unmarried children younger than 18 years pay Rs. 60. An average premium of Rs. 100 is expected and regarded as sufficient for sustainable operations.

The figures from the first year (2003/04) of operation corroborate this assumption: the average price per surgery was Rs. 11,650 and surgery was only required by 0.56% of the clients. However, since many clients did not know how to claim benefits, the percentage of clients claiming is likely to increase in the future.

Third party administrators, like FHPL, are for-profit companies. But FHPL implements the scheme on a non-profit basis. It cannot be verified whether this statement is true. Apart from direct financial profitability, the scheme is beneficial for FHPL in terms of gathering

experience in the market at “the bottom of the pyramid”. FHPL is one of the few players in the Indian insurance sector who view the huge market of poor as a real business opportunity that needs to be developed. It is clear for FHPL that making small profits a million times accumulates to a huge profit for the company; a solid business vision.

The prices fixed for surgeries in the hospitals does not allow for the generation of profits. They are fixed about 30% under the average price for the respective surgery. A detailed comparison conducted by one of the hospitals about the prices paid by Yeshasvini and the rate normally charged by the hospitals shows that some surgeries have been conducted with profit while other induced losses. Calculated over all 57 surgeries conducted, the income earned from Yeshasvini’s clients was about 30% less. The clear incentive for many hospitals to participate in the scheme is the higher utilisation rate of the facilities and the staff.

Table 5.1 Key Results

	2005	2004	2003
Net income (net of donor contributions)	-	3,100,000 (est.)	2,266,000
Total premiums (value in US\$)	3,850,000	3,000,000*	2,182,000*
Growth in premium value	28%	37%	-
Claims / total premiums (%)		140%	110%
Administrative costs / premiums (%)	~5-6%	~10%	~10%
Commissions / Premiums (%)	2.4%	3%	~ 4%
Reinsurance / Premiums (%)	n.a.	n.a.	n.a.
Reserves added for the period / Premiums (%)	-	-12.8%	33.7%
Net income added for the period / Premiums (%)	-	3.3%	3.8%
Claims cost per total number insured	-	4,188,636	2,395,000
Growth in number of insured (%)	-34%	37.5%	n.a.
Income earned from investment of premiums (US\$)	-	100,000 (est.)	84,000
Percentage of profit distributed	0	0	0
Renewal rate (%)	n.a.	69% (est.)	n.a.

* Without government subsidy

Surpluses from one year are kept as reserves for following years. After the Year 1, Rs. 32,300,000 (\$735,000) was kept as surplus. There is no special investment policy for the surpluses yet.

5.4 Impact on Social Protection Policy

Yeshasvini’s Health Scheme demonstrates that it is possible to reach high numbers of insured by cooperating with an established structure reaching out to the rural masses and that modern and expensive surgeries can be made available to the poor if many people pay a small premium. This huge membership that stimulates visions to replicate the success of Yeshasvini in other states. Some state governments approached Yeshasvini Trust to learn from its experience and similar schemes are now planned in Rajasthan and Gujarat now.

Yeshasvini Trust, especially Dr. Devi Shetty, constantly seeks new ways to improve the health situation of the poor. Other projects have already been initiated and cooperation with the government is only sought when needed. There is no lobbying concept targeted on the achievement of a special goal, but more a general advocacy for action in this area – and it is the policy of Devi Shetty and Yeshasvini Trust to be a good example for taking action.

6. Microinsurance Product Development

6.1 Concept Development

The concept for the insurance scheme to cater to the poor was developed by Dr. Devi Shetty and his team. He recognised that it is not the lack of health care supply that leads to unfavourable health status of the poor, but rather their inability to pay for quality care. Insurance promised to be a viable solution.

Dr. Shetty's Narayana Hrudayalaya hospital conducted a pilot study to shed more light on the health seeking and spending behaviour of the poor. The study revealed the vicious circle of ill health and poverty, especially when serious treatments are needed. The research found that the financial capacities of most farmers would be exhausted by the time a health problem is diagnosed. Surgery could not be afforded. This is where Dr. Shetty and his team decided to enter the game. Surgeries are low frequency but relatively high cost events; they can be insured if the number of members is large enough.

6.2 Product Design

Based on the pilot study they conducted and the experience gathered in their own hospital, product design started.

It was important to establish a distribution mechanism that had the capacity to reach out to large numbers of people. The cooperative sector offered such an institutionalized structure. To establish a successful collaboration with this sector, Dr. Shetty approached the Principal Secretary in the Department of Cooperation, Mr Ramaswamy. The principal secretary liked the idea and helped push the concept forward.

A team in Dr. Shetty's hospital developed the product. They defined a list of surgeries to be covered in the scheme. To avoid price escalation, prices were fixed for all surgeries. To calculate the prices, the team reviewed price lists of a number of hospitals and defined an average for each surgery covered in the scheme. As the scheme is designed for rural poor, prices were reduced by 30%.

This price list and the idea of the scheme were presented to a number of hospitals throughout Karnataka to invite them to join as Network Hospitals. Initial success was limited and only a few agreed to join. It was only on the personal intervention of Dr. Shetty that a sufficient number of his colleagues agreed to try it. The incentive for their hospitals was – besides the social character of the scheme – to reach a better utilization of their facilities. The administration of the scheme was outsourced to FHPL. The costs connected to the development of the scheme were borne by Narayana Hrudayalaya.

6.3 Rollout and Review

In the beginning of the scheme, efforts to convince the cooperative sector were concentrated on few big federations and their member cooperatives. In later stages, more smaller cooperative sub-sectors were approached as well.

External researchers conducted some evaluations of the scheme. The only study soon to be available to the public was done by Kuruvilla/Liu/Jacob. It was an evaluation after the first year of operations.

7. Conclusions

7.1 Significant Plans

Yeshasvini Trust is – and can be – satisfied with the basic performance of the scheme and the benefits covered. One of the main concerns is its financial stability. Linking to an insurance company, ICICI, was considered and terms were negotiated. ICICI even agreed to share profits in good years, but to compensate for bad years. This option to transform the self-funded scheme into a partner-agent model was seriously discussed in the trust. However, the trust feared losing ownership and control of the scheme and the partnership was refused. Reinsurance is the favoured option now.

The trust further recognised that it needs to improve information and communication to its clients significantly. More attention will be paid to this issue to help prevent dissatisfaction and ensure that only well informed clients join voluntarily. Increasing the number of clients is another objective connected to this measure.

A slight modification of the benefit package, in terms of surgeries covered and perhaps the adoption of some new fixed rates is also planned. The prices for many surgeries have not changed in the last two years and they were not adjusted to inflation. In terms of real purchasing power, the hospitals earn less than at the beginning of the scheme.

In the current institutional setting, the Principal Secretary in the Department of Cooperation plays a crucial role in pushing the scheme forward due to his personal commitment. This position is subject to regular rotation. It is unclear how these changes will affect the development of the scheme.

7.2 Key Issues Summary

The major breakthrough of this scheme is without doubt insuring so many people in such a short time, which was only possible through the strong partnership with the Department of Cooperation. It used its authority to make cooperative societies actively distribute the product in one way or the other. The network of well-reputed private hospitals made the product even more attractive.

It is remarkable that the Yeshasvini scheme is likely to be financially self-sustaining from the third year of operation. The subsidies the scheme received so far seem to be well invested.

However, the scheme still faces a number of challenges:

- *Limited benefit package*: The benefit package mainly covers classical insurable event that are high cost and low probability. This arrangement supports the financial stability of the scheme and – without question – it helps many poor clients to get surgeries that they could otherwise not or could hardly afford. The inclusion of free OPD in the benefit package protects clients from another source of financial hardships. However,

there are many exclusions constituting a considerable risk for impoverishment to the household. Hospitalisation without surgery is the most prominent one. Of course, it is nearly impossible to offer comprehensive coverage for low premiums, but the scheme needs to find solutions to include the most important services.

- *Communication:* Relying on the strong and partly hierarchical structure of the cooperative sector, the scheme neglected extensive communication with clients. Many clients are not aware of the benefit package details and how to obtain benefits, which leads to unnecessary dissatisfaction.
- *Faster pre-authorisation:* The claim process is organised consistently and logically. Nevertheless, it needs to be adapted to the needs of the clients. An authorisation for surgeries taking days imposes costs (e.g., through additional travel costs) or opportunity costs of being unable to work while waiting. Technical possibilities should enable faster processing.
- *Decentralization:* Karnataka is a huge state and Yeshasvini has not responded to the geography by decentralising some of its structure. Pre-authorisations, at least for smaller surgeries, could be delegated to the district level and would allow faster processing and monitoring of claims.
- *Governance structure:* The board of trustees is composed half of representatives of the Department of Cooperation; although the department facilitates the contact with the cooperative sector, it has to be borne in mind that the cooperative societies have the main burden. It might therefore be advisable to replace trustees from the government by elected representatives of the cooperatives to better reflect their important contribution. As India is currently delinking the cooperative sector from the government structure, it might be adequate to reflect this in the board of trustees as well.
- *Review some processes:* The general process of authorising surgeries is very good, however it does not make sense to request a referral letter from the cooperative at every point in time. This process should be abolished and only requested if ID cards are not issued. The same is true for the practice of requesting recommendation letters from the Department of Cooperation or other government institutions to speed up the authorisation process. As the over-reliance on these letters can damage the scheme's reputation, a clear communiqué should call for discipline in the government's departments and among the network hospitals.
- *Network Hospitals:* The network of well-reputed high quality hospitals is an attractive feature of the scheme. Unfortunately, many clients have to travel long distances to reach a network hospital. The scheme will have to balance concessions in quality with the benefits of increased accessibility. Further, the communication towards the network hospitals needs to be improved. Strong internal marketing needs to be introduced to motivate the staff involved and to inform them about changes in the scheme.
- *Control adverse selection:* Although the average claims per insured are not yet as high as expected, a good amount of adverse selection can be assumed. Cooperative members choose the other members of their households who join the scheme and they are likely to choose those are most likely to need surgery (see Box 7.1). Offering a reduced rate if the full household insures could be an incentive to avoid this kind of adverse selection.

Box 7.1 An Illustrating Example

“Gora B. (Bijapur District, north Karnataka) had excess growth of muscles on her back that caused pain in both legs. She went to consult a doctor in Kohlapur (Maharashtra) who charged Rs. 3,000 for each of her two visits, but could not cure her pain. While taking treatment from this doctor she was not a member of Yeshasvini, unlike her husband. Afterwards she became a member of Yeshasvini and eventually was operated at Narayana Hrudayalaya (Bangalore). She was accompanied by the society chairman and Yeshasvini paid the full surgery cost of Rs. 35,000.”

(Source: Harikrish V., G. Leppert, Th. Wiechers (2005): Summary of Findings about Yeshasvini Trust. Report to the project “Strengthening Micro Health Insurance Units for the Poor in India”.)

This example perfectly illustrates some key points:

- Yeshasvini enables access for the poor to important surgeries.
 - Adverse selection is likely to happen.
 - Patients travel far to some prominent network hospitals instead of using local ones; this leads to uneven distribution of utilisation among the hospitals.
- *Control of fraud:* There are some loopholes in the scheme that might allow for fraud. The current mechanisms are not yet sufficient and need to be strengthened.
 - *Reinsurance:* The scheme needs to ensure its long-term financial viability regardless of the possible number of bad years. As the trust decided not to hand over the scheme to an insurance company, a reinsurance arrangement is needed. Since reinsurance for self-funded micro-schemes does not yet exist in India, the trust might wish to advocate for the establishment of such a facility.

Annex 1: Pre-Authorisation Form

FAMILY HEALTH PLAN LIMITED YESHASVINI CO-OPERATIVE FARMERS HEALTH SCHEME - 2004-05 <i>First Admission Report / Initial Intimation Report</i>	
Date & Time of request : _____ Receipt No. : _____ ID No. : _____	
Name of the Patient: _____ Main member / Dependent (Relation with main member : _____) Age: _____ Sex: M/F _____ Religion: _____ Caste: _____	
Co-operative Society Name: _____ District: _____	
Name of the Hospital: _____	
She/He has presented with following signs/symptoms: _____ _____ _____	
Past history of Patient: _____ _____ _____	
Surgery required: (Plan of treatment) _____	
Probable Date of Admission: _____ Emergency/Elective _____	
Registration number of Treating Doctor _____	
Signature of Treating Doctor with Seal _____	
FOR FHPL OFFICE USE	
Medical officer (FHPL) Sanctioned Amount _____ Remarks _____ _____ _____	fhpl/Yes/2004-05/ _____ Internal Audit (FHPL) Remarks _____ _____ _____
Signature: _____	Signature: _____
NOTE: 1. This pre-authorization is being given by FHPL on behalf of Yeshasvini Trust formed vide Trust Deed dated 10.11.03. The primary liability to make the payment to the hospital providing services based on the pre-authorization is that of the Yeshasvini Trust and not FHPL. 2. I undertake that in case of availing cashless facility all original documents, including the discharge summary and investigation report will be handed over to the hospital at the time of discharge along with signed claim form. I am aware that without these documents the scheme can't be processed and in case of non-compliance I am liable to pay for the same. 3. I undertake to pay for all non-medical expenses incurred in the hospital at the time of discharge. Non-medical expenses include Reg.Fees, F&R, Ambul., charges, Med.refd.charges, attendant pass charges; toiletries are considered as non-medical expenses as per the scheme. 4. If the above hospitalization comes under any of my scheme exclusions and not reimbursed by the above mentioned office, I undertake to pay the amount to above hospital that have kindly extended the hospital credit facility.	
Signature/Thumb print of the member _____	
N.B.: ➤ Please note that the FAR has to be sent to FHPL office within 24 hrs from the time of admission in case of emergency and it has to send before admitting the patient in case of planned admission. ➤ Denial of Pre-authorization doesn't mean denial of treatment. Hospitals may extend the required treatment to the member	

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Special Features

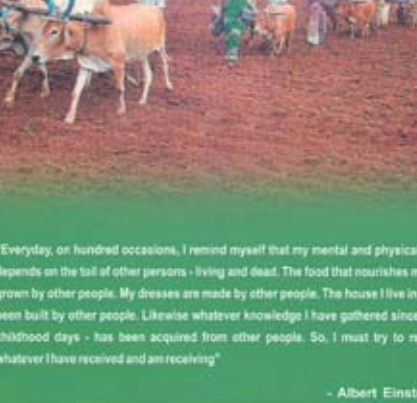
- ♥ A Member who has been a member of a co-operative society for at least 6 months can avail the benefits of the scheme for paying a nominal sum of Rs. 500 per year for the wife and children can also avail the benefits by paying Rs. 500 per annum.
- ♥ Suffering from any kind of disease is no bar to avail the benefits of the scheme.
- ♥ Upper age limit to avail the benefits of the scheme is 75 years.
- ♥ Members can avail free surgery costing up to Rs. 7000 fully and Rs. 9000 semi for multiple surgeries.
- ♥ 1,800 types of surgeries have been included in the **Yeshasvini Scheme**, details of which are available on the website.
- ♥ One Hospital which comply with the parameters set for the Mahatma Trust and recognized as National Institute, District Commissioner in their district acts as Nodal co-ordinator at the activities with the District Degree of Co-operative Societies of the district functioning as Member Societies.

Progress achieved

- ♥ In the first phase of the project 1987-1989 services were provided under the scheme. In the second phase, over 800 more families have been benefited.
- ♥ The Year-End meeting of Karnataka State Co-op Society had a inspiring hand and contributed Rs. 4,200 crores to the Finance Department is also committed to give a sum of Rs. 100 crores to the Yeshasvini Trust during the year 2024-25.
- ♥ Over 10,000 surgeries of various kinds have been successfully conducted on beneficiary co-operative members as on December 2024.
- ♥ Nearly 60,000 service cooperatives have started free CMO facility located at Rs. 14 million as on December 2024.
- ♥ 126 Network Hospitals have been recognised all over the State of Karnataka.

Programme for 2004-05

- ♥ To identify hospitals and nursing homes at sub-district and taluk levels so as to provide healthcare at the nearest doorstep.
- ♥ To use an effective extension work and create awareness among farmer co-operatives about the scheme.
- ♥ Networking of all accredited hospitals and sources of computer - based credit cards to beneficiaries co-operative members.

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"Everyday, on hundred occasions, I remind myself that my mental and physical life depends on the toil of other persons - living and dead. The food that nourishes me is grown by other people. My dresses are made by other people. The house I live in has been built by other people. Likewise whatever knowledge I have gathered since my childhood days - has been acquired from other people. So, I must try to repay whatever I have received and am receiving"

- Albert Einstein

Punjab was the first state to usher in the Green Revolution (Agriculture) through its network of Co-operatives. Gujarat led the White (Milk) Revolution through its network of Co-operative Milk Unions.

Now, Karnataka leads the nation in Healthcare Revolution through its Yeshasvini Co-operative Rural Healthcare Scheme.

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