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Brief Technical Report on Swasthyapurna Mutual Health Fund

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Introduction

This report is based on data collected during a 10 weeks research in Pune District, India, from October to December 2003 funded and kindly supported by GTZ.
The purpose of the whole study was to get an insight in the evolving health microinsurance schemes in Pune District.

Part of the research was a case study of Swasthyapurna Mutual Health Fund[1]. To study the organizational structure of the scheme the InfoSure-tool was applied. InfoSure is a computer-based questionnaire consisting of 150 questions covering all aspects of health insurance schemes. The dualistic structure of a quantitative and a qualitative part of the questions secures that data can be compared with other schemes while no information is lost. The tool was developed by GTZ.

24 interviews with the target group using a semi-structured interview guide were conducted to characterize and clarify the structure of the demand side of the scheme.

This paper offers a brief description of the scheme and a summary of the findings of the interviews. The strengths and weaknesses of the scheme are highlighted followed by some recommendations for future improvements.

Brief description of the scheme

Offering Organization

The Swasthyapurna Mutual Health Fund is offered by Annapurna Pariwar Pune (initially founded as a women self help group under the name 'Annapurna Mahila Mandal') supported by the French Inter Aide.

Both organizations form part of the Uplift Network India, a network of several organizations with the objective to help the poor in the urban slum areas. Their instruments are micro finance for entrepreneurship development, job placement, and mutual funds for health risk management through solidarity.

The organizations in the Uplift Network India are groups like 'Navnirman Samaj Vikas Kendra' in Malad, 'Annapurna Pariwar Pune', 'Parvati' and 'Vikas' in Pune slums, 'Disha Kendra' in Yerwada, 'D.I.S.H.A.' in Pimpri Chinchwad and recently, 'Annapurna Mahila Mandal Cooperative Credit Society' in Mumbai. This network gathers also organizations providing central services like 'Swabhimaan' (technical support) and 'Inter Aide' (activities follow up and funding support).

The Uplift Network is used for spreading the idea of the Mutual Health Fund, which was first implemented by Annapurna Pariwar Pune.

[1] Here, we would like to express our deep gratitude for the friendly support experienced by the staff of Swasthyapurna, namely Rajashree Kasote, F.X. Hay and Dr. Prashant and the members of the Health Fund who took part in the interviews. We also thank Anagha Joshi for her patience and excellent translation.

The target group

The scheme was created in 2003 for urban slum dwellers in Pune City. In the first step mainly the members of Annapurna Pariwar Pune are considered as target group, but the project is open to each poor family in the area.

The dwellings of the target group are concentrated in urban slum areas spread over the western and southwestern parts of Pune City. The biggest distance between these areas is approx. 12 kms.

The geographical roots of some Pune-slum-dwellers of that area are lying in problematic and arid rural areas (e.g. Indapur-block) and the rate of scheduled castes and tribes (which are still a disadvantaged group of the Indian society) is higher than average.

Corresponding to a 1,000 household-survey conducted by the organizers in the target area during the setting up period of the scheme, the majority of these households (86,3%) considered the husband as the earning head of the family. One half of them are self-employed, 20% have an instable income (daily wages), but only about 1% of them have no job at all. In 90% of the cases the wife is considered as the second head of the household. Women are mainly working at home e.g. as stitchers, but due to the projects of Annapurna Pariwar Pune, in the field of “micro entrepreneurs” counselling, skill training, job placement and vocational trainings, a bias concerning the 'Annapurna working ladies' plays a role here, since there is a higher percentage of self-employed ladies (33,16%) than average. In case of self-employment the activity may be seasonal e.g. if it involves the sale of fruit or vegetable.

70% of these members’ families are living with less than Rs 1,000 per month per person.

Middle and high income-groups are intentionally excluded from the scheme. These groups have the capacities to manage health expenditures on their own.

Contributions

In the design of the scheme the group was asked how much contribution they are willing to pay. The benefit package was designed according to their willingness to pay.

Each member pays Rs 50 a year if its whole family joins. If not the family as a whole joins the scheme the individual has to pay the double premium. Alcoholics and members aged above 60 years pay Rs 100.

Contributions have to be paid in cash. A one-time payment for a whole year has to be made although some are allowed to pay in instalments in the initial phase of the scheme (to get a bigger number of insured quickly).

The current and the prospected members of the insurance have the possibility to take loans from Annapurna Pune micro credit programme (not offered by the mutual fund) and could pay their premium out of this.

The contributions are mainly collected at the headquarter of Annapurna Pune or at their (mobile) branches. Because Annapurna is offering an 'all-through-one-window' service, the contribution payment could easily be made in every branch. Furthermore two field workers of Swasthyapurna (currently one social worker and a medical doctor) conduct the collection of the contributions as well.

To join the scheme the prospective members fill in a form containing the name of the policyholder and information about the insured members of the family. A sheet covering all pre-existing diseases is part of the enrolment-form as well. Using this data an Insurance Card with a photo of all family members and information concerning their health is created. The data about the payment is kept with the fund and is available when a decision about the claim has to be taken.

Benefits

Up to 80% of the costs of a **hospitalisation** due to the 11 most frequent diseases are covered up to a ceiling of Rs 5,000 per year and person.

These diseases are:

Caesarean (up to Rs 5,000),
Limbs Paralysis (up to Rs 5,000),
Fracture (up to Rs 5,000),
Pneumonia (up to Rs 5,000),
Critical Surgery (up to Rs 5,000),
Kidney Stone Operation (up to Rs 2,500),
Hernia (up to Rs 2,500),
Urinary Infection (up to Rs 2,500),
Jaundice (up to Rs 2,500),
Typhoid (up to Rs 2,500),
Malaria (up to Rs 1,000).

20% of all reimbursable costs (hospitalisation) and every amount exceeding Rs 5,000 have to be borne by the individual.

The benefits provided are defined by regulation. A little arbitrary possibility in decision remains with the claim committee; for example when decisions have to be taken whether an illness follows a pre-existing disease (and therefore is excluded). If the fund once runs small in budget arbitrary measures might be used as well. (A lack of funds has not occurred yet.)

If a member has to use health facilities, **guidance** by the Mutual Health Fund is offered to consult the member on treatment and provider options. Through this service the cost of a single claim should be kept as low as possible while ensuring the best possible treatment for the insured. On the basis of the bills and a crosschecking with the doctors and neighbours (to avoid fraud) the reimbursement is done according to the rules and the decisions of the claim committee.

At least once a year **health check-up camps** are organized in the residential areas of the target group. These can be general check-ups or specialized in e.g. eye-health, vaccination, etc.

Exclusions

All diseases not mentioned in the list above are excluded as long as the claim committee takes no other individual decision.

Pre-existing diseases and illnesses directly related to them are excluded as well as transport and OPD treatment.

Members might get trouble with the reimbursement in the long run if they repeatedly threaten their health careless.

Practical organization

The Swasthyapurna Mutual Health Fund is currently organized in three levels; a fourth one is planned:

1. Group level
2. Cluster level
3. NGO level: Swasthyapurna staff together with Inter Aide and cluster representatives
4. Federation level as reinsurance (planned).

The first organizational level is the group level. One group contains 4 to 5 families, which join the mutual fund together. Normally these groups already exist as saving groups (so called Common Goal Groups (CGG)) under the Arthapurna (women) or Udyampurna (men) scheme offered by the umbrella organization Annapurna Pariwar Pune. A big part of the recent members of the Mutual Health Fund are recruited from these groups. In their monthly meetings and at the different loan desks they get informed about the possibility to join the Mutual Health Fund by the staff of the Annapurna Organization. As the membership is not compulsory the decision to join the scheme remains with the individual.

The registration of a group of families is then to be made at the Annapurna head office or one of its branches. Each family has to fill in their form and additionally there has to be one group policy form countersigned by all the group members. Through this procedure the choice of new members remains within the single groups but the final decision is with the Swasthyapurna staff. Together with the registration the contributions are collected at the registration points mentioned above. Until now the contribution collection is not as formalized as it should be, so that there are some members who are registered but have not paid their contributions yet.

The groups of 4-5 families are at the second level organized in clusters within a geographical area. The contributions paid by the group members of one cluster remain with this cluster for the reimbursement of the claims. A certain part of this money is put aside for the financing of Swasthyapurna fund, which can be used as a kind of reinsurance for each cluster.

Each cluster has a cluster fund committee, which consists of 2 or 3 members, the Swasthyapurna medical doctor, the social worker and (in case) an additional technical representative. This committee takes the decisions about the claim settlements, reviews the fund's balance and shares information about the other programme activities.

At the third organizational level there is the Swasthyapurna Insurance Committee consisting of one representative of each cluster, the Swasthyapurna medical doctor, the social worker, and (in case) an additional technical representative. In this committee the cluster fund's claims are decided, the fund balance is reviewed and information about the other programme activities is shared.

The Swasthyapurna staff together with Inter Aide (a French partner in the Uplift Network) administers the financial management, the statistics, the bookkeeping and the health information and promotion.

The healthcare provision is administered by the local public and private health facilities. The Swasthyapurna staff together with Inter Aide reviews the local providers and their offers especially for the poor. Through this they can offer their members guidance to the best and cheapest facility according to each case of illness.

There are plans to introduce a fourth level, which would contain different health mutual funds of other organizations to contribute to a 'reinsurance fund' at this level.

In case of any illness the member of the fund is requested to visit or call the Swasthyapurna head office, which then guides the patient to the hospital.

The patient pays the bill for treatment and medicine to the hospital in cash. He hands over the claim documents to the social worker of Swasthyapurna. The Cluster Fund Committee then takes the decision about the reimbursement and the social worker pays the amount to the member.

Members

In the first year of existence of the scheme (2003) 3,523 members (839 families) subscribed to the fund, out of which 2,200 contributed their premium. 1,323 subscribers still have not paid their premium. The Swasthyapurna staff is thinking of cancelling these contracts in near future.

Until now there are five claims, some of them are still in process others successfully settled. The claim ratio after 6 month was at 20%.

Long-term goals

In the long run, the organization wants to extend the scheme to more members (up to 100,000). Therefore they try to renew the enrolments for the second year, create a bigger awareness about the Mutual Fund and about health behaviour under the members of the target group and get a better control over the collection of the premium.

A federation of Mutual Health Funds of other organizations should be build up as a kind of reinsurance.

Annapurna and InterAide want to spread the idea of Mutual Health Funds to other NGOs and they try to negotiate with healthcare providers, to elaborate special offers for Swasthyapurna members.

Summary results of the interviews with the target group

In the interviews with the target group 24 respondents were asked in three different slum areas about several points regarding their health behaviour and their relationship to Annapurna Pariwar Pune in general and to the Swasthyapurna Mutual Health Fund in particular. Three quarters of the respondents were already members of the Fund and as well three quarters were female.

The average[2] household size of the persons interviewed is 4.00 ranging from a single person household to a household of 8. The average income per household of the interviewed as they told is Rs 3,381 per month; the average monthly per capita income is Rs 940.25 ranging from Rs 70 to Rs 3,000. One family lives below poverty line (Rs 264/person and month) in terms of cash available, 4 families have an income up to Rs 500, 12 families up to Rs 1,000 and 7 more than that.

Asked about their strategy to cope with an unexpected deficiency of income (in a multiple choice answer) the respondents answered at 40-60% with each of the following answers: borrow money (from relatives/ friends or neighbours) (16 resp.), taking a loan from Annapurna (12 resp.) or spending less on cloths, religious purposes or on food (15 resp.). Almost nobody could or would sell any assets. Only very few would borrow money from a moneylender or a Bishi. There are only three people who would not borrow money at all. These figures might show, that the Mutual Fund can replace the borrowing mechanisms and the restrictions on the respondent's expenses up to a certain degree in case of unexpected health expenditures.

Asked in another way, 7 of the 17 respondents who already borrowed money once borrowed it for health purposes.

All interviewed persons who are a member of an Arthapurna/ Udyampurna group (14 resp.) joined this group because of the possibility of credit, a part of them also for saving. Only two persons joined the scheme only due to the persuasion by their relatives. Most of the CGG members think the membership changed their behaviour and feelings. The main points mentioned here were the gaining of information, the widening of their horizon and an increased self-consciousness. Only one member told us about the improvement of her economic situation. This means that the economic component of the CGG is the main aspect for the members to join the group but the effect must also be highlighted in terms of social empowerment rather than solely economic dimensions.

When asked about their habits in using health facilities just two stated that they use ayurvedic or homeopathic medicine (for minor illnesses).

[2] The size of the sample is too small to conduct statistical operations, which are reliable. Nevertheless, some mean values should give a very rough idea of what we are talking about.

Just 5 of the persons interviewed use governmental facilities. Most use it for major purposes like hospitalisation because it is cheaper than the private facilities. Just one person states that the quality of care in the governmental facilities is good.
All use private facilities. Many use it for all purposes, some just for minor illnesses because they cannot effort bigger treatments there. Seventeen respondents use it because it is the closest and 16 stated that it gives the best treatment. Surprisingly 14 of the interviewed stated, that the private facility they use would be the cheapest facility.
Half of the persons stated to use a pharmacy (7 use it for self-medication purposes and 5 only after prescription by a doctor).
No matter which facility (private or public) the interviewed persons use, there is a big trust in the doctors.

Asked about the reason for joining the insurance scheme nine persons highlighted the reimbursement and therefore the economic aspect as a reason. The guidance to a good health facility was another reason to join for three members. The solidarity with others was for two of the interviewed persons a reason to join. They appreciate the fact that they help others with their contributions if they do not fall sick themselves. Two people joined because they fall ill very often and four considered the Fund as help without any specification.

Out of the six persons who have not joined the Mutual Fund yet four would be interested to join: two are waiting to form a group, one has no ration card (official ID-card) and therefore has problems to join and one has to ask his father to make the decision. Two of these six do not want to take part in the Fund: One because he is already insured under the ESIS scheme (Employees' State Insurance Scheme) and one shows no interest at all.

Regarding the knowledge of how an Mutual Fund works exactly, the respondents, which take part in the Mutual Fund, can be divided in two big groups: Two third of them explicitly knew about the solidarity mechanisms working in the Mutual Fund. One third did not know what happens to their premium at all but still considered the scheme as beneficial or had positive associations.

The knowledge of the non-insured respondents about mutuals/ insurance was less differentiated but they also had positive associations.

When talking about the details of the scheme and asking for suggestions to improve the benefits, the answers were as follows (number of persons in brackets):

- (1) Higher coverage through more members.
- (3) Higher coverage through higher premiums.
- (1) Higher coverage but is not able to pay higher premium
- (1) More health check-up camps.
- (1) Maximum benefits should be given.
- (1) Chronic illnesses should be covered as well.
- (1) Old age diseases like diabetes should be covered.
- (1) Every illness should be covered.
- Eight persons had no suggestion.
- Six persons were not taking part in the Fund.

When asked (16 persons) only two had suggestions for the improvement of the claim settlement. They think the conditions should be more flexible. One of them does not like the condition of informing the Swasthyapurna staff before seeking treatment.

There are many people interested in joining the scheme but the members of the Mutual also heard several arguments for not joining the scheme. Some say that the money is lost if they do not get ill. For many the lack of money hinders them to join with the whole family and some feel that they never get ill and therefore do not need such help. Most of the members try to convince the people of joining the Fund; some already convinced some new members.

In the perception of twenty of the interviewed persons there is a danger of a financial collapse of the household due to unexpected expenditures for health. The risk of such a financial collapse is reduced in the opinion of all of them through the Mutual Health Fund. Nobody denies that insurance reduces this danger.
Three of the persons interviewed are not afraid of financial collapse caused by illness at all.

If the persons interviewed could create their own benefit package for the Mutual Fund by choosing only three benefits out of a list of hypothetical possibilities offered (containing also some non health related features like scholarship or life insurance) most of the packages would include:

1. Covering of the costs of hospitalisation (mentioned by 17 persons)
2. Scholarships for the children (mentioned by 14 persons)
3. Reimbursement of medicine (mentioned by 7 persons)

The persons were asked to bring the three most important in an order. The following table shows the number of persons who judged a certain benefit to be most, second or third most important in a potential scheme and the total number in the last column.

Possible benefit to be included	**Stated to be most important**	**Stated to be second most important**	**Stated to be third most important**	**Total**
Hospitalisation	6	5	6	**17**
Maternity Benefits	0	0	1	**1**
Disability Coverage	0	0	1	**1**
Reimbursement of medicine	2	4	1	**7**
Ayurveda/ Homeopathy	1	2	1	**4**
Chronic Diseases	1	0	2	**3**
HIV/ AIDS	0	0	0	**0**
OPD*	0	1	3	**4**
Dental	0	0	0	**0**
Glasses	0	0	0	**0**
Compensation**	1	3	1	**5**
Life Insurance	1	2	0	**3**
Scholarship	8	3	3	**14**

* Outpatient treatment.
** Explained as follows in the interviews: “If the earning head of the family is ill for a couple of days the insurance should pay a certain amount to the family for each day of income loss except the first three days.”

Strengths

- In the set up phase of the Mutual Health Fund a survey was conducted to find out about the needs, possibilities and expectations of the target group regarding the Fund. That way the "product offered" is a tailor-made one under the given circumstances.

- Annapurna Pariwar Pune is a well-known organization amongst the target group. As they are working in those areas since years, there is already a relationship of trust between the organization and the target group. This helps to communicate the idea and the concept of the Mutual Health Fund

- The high grade of participation of the members in the whole process of the claim settlement is a very good instrument to communicate the operation of the Fund in detail. Through this procedure the Fund remains partly in the hands of the members and the idea of solidarity within the Fund becomes understandable for the participants.

- The whole organization of Swasthyapurna has still a "human" size. The members of the Fund are in contact with the staff of Swasthyapurna and they know to whom to talk to when they have a problem with the scheme.

- Guidance is offered by Swasthyapurna to consult the members on treatment and provider options. It has some positive effects: the financial burden of the patient as well as of the Mutual Fund is reduced while a good quality treatment is guaranteed. The organizers are beginning to use their overview over the health market and their position to negotiate better conditions with the health facilities for the members of the Fund.

- The Swasthyapurna and Inter Aide staff is very engaged in spreading the idea of the Mutual Health Fund not only in the target group but also under other NGOs, which could build up their own Funds. They lay big efforts in the discussion of the concepts and the practical organization of such a Fund to make a replication possible.

- The premiums for the Mutual Health Fund are very low especially compared to the official insurance schemes offered by insurance companies. This is partly due to the subsidies of Inter Aide for the administrative part of the project and the limited coverage. The low premiums open up the Fund for more people who could not effort another scheme.

- To avoid adverse selection higher premiums have to be paid when the family does not join as a whole. This is a good instrument to make sure that neither only the heads of family join without their partner or children nor that only the weakest family member joins. Higher premiums have to be paid as well if the member is an alcoholic or older than 60 years.

- The membership of the Fund is organized in groups of four to five families. Swasthyapurna follows the idea of taking care of one's own health behaviour

and the health behaviour of others. The feeling of responsibility for friends and neighbours (group members) shall be raised through this.

- Through the organization in clusters and the discussion of any single claim the Fund can remain more flexible for changes in the statutes as well as for exceptions from the rules in cases of hardships of single members as an insurance company could be.

- The existence of CGGs is an asset for the members not just in terms of personal development of skills and confidence but as a possible source of credit for various purposes and especially to bridge the gap between out of pocket pre-payment at the health care facility and the reimbursement by the fund.

- The health check-up camps (free of cost for Fund members) seem to be a positive incentive for many members and potential members. Generally, the members are interested in getting value for their money if they do not fall ill.

- The existence of an insurance card for each family is an advantage in two ways, it simplifies the administration and it helps to make the members feel to have a good value for their money (simply to hold something in their hands).

Weaknesses/ Threats

- The financial strength of the Fund is not guaranteed due to the lack of a proper reinsurance. If the fund once runs small in budget arbitrary measures have to be used as well. In that case members may lose their trust in Swasthyapurna when they feel cheated out of their money.

- Because payment should be made once a year and claims are covered through reimbursement there should be no need to enforce contribution payment. Until now the contribution collection is not as formalized as it should be. Out of the total number of 3,523 subscribers to the Fund 1,323 have not paid their (whole) premiums yet. Swasthyapurna is now forced to expulse some members from the Fund.

- A part of the administrative costs of the Mutual Health Fund is borne by Inter Aide. It is questionable that at any time the fund will be able to exist financially absolutely independent without raising the premiums, because the effort of servicing the members and giving information is very high.

- Some members are not satisfied with the amount covered in case of hospitalisation.

Recommendations

- The idea of building up a federation of Mutual Health Funds to act as a kind of reinsurance should be followed as quick as possible to avoid a financial collapse (for example in the case of an epidemic).

- The list of public and private healthcare providers and their price schedules including their special offers should be completed with as many as possible facilities in the target areas to improve the service of guidance and maybe to increase the number of covered diseases based on this list. If there are very cheap offers for certain diseases (provided good quality treatment) the coverage for those diseases could be added to the statutes of the Fund.

- Maybe special offers could also be negotiated with the providers.

- Because many members of the Mutual Health Fund wish assistance for education expenses Annapurna could think of the introduction of some kind of scholarship or a saving instrument for these kind of expenditures. This could be separated from the Swasthyapurna Mutual Health Fund.
  LIC offers such a scholarship for members covered under the Janashree Bima Yojana life insurance (which is Rs 100 a year[3]). The name of this scholarship is Shisksha Sahyog Yojana. The number of these scholarships is limited; it is granted to the poorest families applying. Maybe Annapurna could ask the local LIC agency for further details and think of acting as a nodal agent for that scheme.

- The contribution collection has to be formalized more strictly, to make sure that all members actually have paid their premiums. If it is a big problem of the members to get the money in time, Swasthyapurna could think of introducing the option of saving a certain sum, which would make it possible to pay each years contribution out of the interest of this sum. Through this procedure the members cannot forget to pay their premiums and a constant membership would be guaranteed

- As the contribution has to be paid yearly attention has to be kept on the renewal after one year. There might be the danger of dropouts. Waiting periods might have to start again if contributions are paid with delay – perhaps just when an illness occurs.

- Rules for the claim settlement procedure (time of declaration etc.) should be fixed to create a common base of discussion within the Fund and its members.

- The organization of the cluster fund committee with its regular meetings under the participation of two or three group members should be realized. As of now it is not working properly and it would ease the flow of information.

- Since the scheme does not exist for a very long time (approximately one year) the need to work with statistics was still low until now. The organizers are

[3] If the families' income is around the poverty line.

already aware about this problem in the medium run and they are thinking of solutions to improve the bookkeeping, which would maybe simplify modifications of the scheme in the long-term run.

- Swasthyapurna could think of a second optional benefit package, as there are some members who wish a higher coverage and could effort a higher premium. But this might lead to problems in communication of solidarity; the relationship between contributions and benefits would have to be stressed.