

# **Karuna Trust, Karnataka India**

**CGAP Working Group on Microinsurance  
Good and Bad Practices  
*Case Study No. 19***

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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](http://www.microfinancegateway.org/section/resourcecenters/microinsurance)

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The authors

## Acronyms

APL	Above Poverty Line
BPL	Below Poverty Line
CDA	Cluster Development Associations
CGAP	Consultative Group to Assist the Poorest
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CPD	Centre for Population Dynamics
DFID	Department for International Development
DICGC	Deposit Insurance and Credit Guarantee Corporation
ESIS	Employees' State Insurance Scheme
FICCI	Federation of Indian Chambers of Commerce and Industry
GIC	General Insurance Corporation
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
IEC	Information, Education and Counselling
ILO	International Labour Organization
IRDA	Insurance Regulatory and Development Authority
MoU	Memorandum of Understanding
NGO	Non-government Organization
NIC	National Insurance Company Ltd.
OPD	Outpatient Department
PHC	Primary Health Centre
RBI	Reserve Bank of India
SC	Scheduled Casts
SHG	Self Help Group
SIDA	Swedish International Development Agency
ST	Scheduled Tribes
TPA	Third Party Administrator
UIIC	United India Insurance Company
UNDP	United Nations Development Programme
VGKK	Vivekananda Girijan Kalyan Kendra
WHO	World Health Organization

## Executive Summary

Karuna Trust is an NGO that has been working successfully on health and development issues for nearly two decades. In 2002, Karuna Trust, in a partnership with the United Nations Development Programme (UNDP), decided to implement a pilot health insurance scheme for its target population. The non-governmental organization (NGO) collaborated with the state-owned National Insurance Company (NIC) in designing a health insurance product that complements the public healthcare infrastructure and compensates for some of its weaknesses. Karuna Trust acts as an agent for NIC. The insurance product compensates the insured for the loss of income in case of hospitalization at a public health facility. Furthermore, a drug fund was set up to supply medicines that are unavailable in public facilities. People with income around the poverty line receive treatment in public health facilities free-of-charge. A tight network between the insurance scheme and the public infrastructure has evolved.

A baseline study conducted before the implementation of the scheme revealed that the target group had low understanding and knowledge of health insurance. It was therefore decided to fully subsidise the premium for the very poor. UNDP provided the funding for two years and NIC still accepts a claim ratio of up to 150% because of the social nature of the scheme. It was assumed that, with time, acceptance of insurance and willingness to join and pay would rise among people experiencing the insurance benefits. Extensive information and education was given during the pilot phase. In 2005, premiums were collected from all insured for the first time. About half the members of the subsidized scheme paid to renew their membership. “We know we get value for our money” was a common reason for re-enrolment. However, others complained about having to pay for benefits that were free in the previous years.

The experience of Karuna Trust is a very interesting example of creating complementarities between insurance and existing public structures, and how subsidies help familiarise clients with insurance principles. However, this costly awareness building process was affordable only because external funding was available.

### *Lessons: Outcomes*

- Karuna Trust has shown that making use of the public health infrastructure can be advantageous for all sides:
  - **Clients:** Hospitalization in public facilities is free for all patients with incomes under or close to the poverty level. The insurance product supplements free hospitalizations by ensuring income-replacement, which enables clients to access care. Even though public health care was free-of-charge, it was not accessible to the poor because they could not afford the opportunity costs of being away from work while in treatment.
  - **Public healthcare providers:** Utilization levels and the quality of care improved notably because drugs were supplied through insurance.

- **Insurance:** The product was designed to be complementary, i.e., it does not cover services provided by public providers; therefore, the cost is low for more comprehensive protection, without having to establish a new infrastructure.
- **Lower barriers for seeking care:** Compensation for wage loss is likely to influence clients' healthcare utilization positively—people are less likely to delay seeking care and therefore might enjoy better health status.

#### *Lessons: Product Design*

- **Market research is the starting point:** Solid market research helps create products desired by the clients. The money for such an extensive study seems well invested, although it has to be acknowledged that for most microinsurance schemes, external financial support might be necessary for this.
- **Complement existing offers:** Making use of benefits offered elsewhere (e.g., by the public providers) helps to keep the premiums low while – at the end – offering an effective risk management mechanism for the clients.
- **No risk taking, no innovation:** To design an innovative product, some goodwill on the side of the risk bearing insurance company is necessary. NIC has agreed to give a risky undertaking like compensation of wage loss a try despite some concerns.
- **Do not forget the indirect costs of illness:** Not being able to work and even the transportation to the health care provider constitute a high financial burden for poor households – sometimes as high as the direct costs of seeking care. Karuna Trust takes this into account by compensating for loss of wages and providing emergency transportation to the general hospital.
- **Generic drugs are cheaper:** As long as Karuna Trust reimbursed clients for the drugs purchased, branded drugs were bought. Karuna succeeded to save some costs by providing generic drugs in the health facilities themselves.
- **People care when they pay:** As people start paying for their insurance, they take over ownership and demand quality for their money.

#### *Lessons: Delivery Mechanisms*

- **Strong links ensure good flow of information:** Karuna Trust offers a good example of an effective way of using established NGO-infrastructure to disseminate information about insurance and distribute the insurance product. In Karuna's other activities where health insurance is not offered, the level of knowledge about insurance among clients seems to be significantly lower.
- **“Second best solutions” can improve over time:** Although many clients might prefer private health care providers, they accept using public ones. By compensating for some of their shortcomings (especially drugs), the insurance helps to increase acceptance of public providers.
- **Sometimes it is too far:** When restricting a health insurance scheme to designated facilities, those who live further away are less likely to join.

*Lessons: Marketing*

- **Never subsidize it all:** Full subsidy of the insurance premium enables providers to cover large numbers quickly, however many are not aware that they are insured. By charging even a modest premium, clients would be more aware of the services they have paid for.
- **Invest in marketing:** Insurance does not come naturally to most people; information and education is needed. Karuna Trust only had a marketing budget in the first year of operations. This is partly compensated through the personal contact Karuna has with the target group but some marketing spending would help.
- **Pay premiums during periods of cash surplus:** When Karuna introduced premium payments, it was an inappropriate time for the collection because it was during the months when little employment was available.

*Lessons: Claim Settlement*

- **Settle claims quickly:** Quick settlement of claims prevents households from economic hardship. Karuna Trust usually manages to settle claims before patients leave the hospital.
- **Identify the policyholder:** Karuna Trust requires clients to submit their receipt of premium payment when claiming benefits, but this receipt does not contain a photo of the policyholder. Although many clients are known to Karuna's staff, this is not the case for all clients. A proper mechanism to identify policyholders needs to be introduced.

*Lessons: Organizational*

- **Do not underestimate fraud:** Having many people handle relatively small amounts of money makes it difficult for Karuna Trust to monitor effectively. Fraud is likely to be present at the provider side, within Karuna's structures and can be expected among the clients as well. And many small amounts can quickly sum up to high numbers.
- **Make use of the client base:** More involvement of clients might increase ownership and can be a valuable mechanism to help in reducing misuse of the system. But for this, some risk might need to be shifted to the clients (which means that some profit remains with them in good years).



## 1. The Context

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 diverse people, languages, religions and cultures. Indian 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. The country's economy is growing rapidly.

**Table 1.1 Macro Data**

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

<sup>1</sup> <http://www.cia.gov/cia/publications/factbook/geos/in.html#Intro>

<sup>2</sup> <http://www.unhabitat.org/habredd/conditions/socentasia/india.htm>

<sup>3</sup> <http://www.capitals.com/print/in.html>

<sup>4</sup> This exchange rate will be used in all calculations of current figures in this paper.

<sup>5</sup> <http://www.economywatch.com/indianeconomy/indian-economy-overview.html>

<sup>6</sup> [http://www.undp.org/hdr2003/indicator/cty\\_f\\_IND.html](http://www.undp.org/hdr2003/indicator/cty_f_IND.html)

<sup>7</sup> <http://devdata.worldbank.org/external/CPProfile.asp?SelectedCountry=IND&CCODE=IND&CNAME=India&PTYPE=CP>

<sup>8</sup> [http://www.who.int/macrohealth/action/en/rep04\\_india.pdf](http://www.who.int/macrohealth/action/en/rep04_india.pdf)

<sup>9</sup> 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>

<sup>10</sup> [http://www.worldbank.org/data/wdi2000/pdfs/tab2\\_14.pdf](http://www.worldbank.org/data/wdi2000/pdfs/tab2_14.pdf)

## 1.1 Role of the State in Insurance

The Constitution of India assigns the responsibility for various issues to the Union (the federal government also called “central government”), to the State (any of the individual States), or to both. Insurance is a federal task. The Constitution assigns “incorporation, regulation and winding up of trading corporations, including banking, insurance and financial corporations, but not including cooperative societies” to the union’s responsibilities. The state is involved in the “incorporation, regulation and winding up of corporations (other than those specified in the Union list), and [...] other societies and associations; cooperative societies.” Both, Union and State(s), have concurrent competences regarding “bankruptcy and insolvency” for all entities not further specified, including trade unions, social security and social insurance, as well as charities and charitable institutions.

The insurance industry was nationalized in India, life insurance in 1956 and general insurance in 1973. In 1999, the insurance market reopened for (limited) competition with the entry of private companies, following the establishment of the Insurance Regulatory and Development Authority (IRDA) by an Act of Parliament.

Established by the federal government, the IRDA has extensive duties, powers and competencies to regulate, promote and ensure growth of the insurance and re-insurance industry, including licensing, contractual conditions, standards for qualifications of management and intermediaries, operational affairs and supervision. IRDA also has the authority to launch investigations and conduct inspections of licensed insurance companies at any time it deems fit, and can cancel the registration or close down an insurance firm. The central government is empowered to bypass the IRDA in policy related issues (Section 18, IRDA Act 1999) and may act and supersede IRDA under various conditions, e.g., in the “public interest” (Section 19 IRDA Act 1999).

An “insurance company” in India means any company formed and registered under the Companies Act 1956 whose sole purpose is to carry on insurance or re-insurance business. A foreign company (defined under the Income-Tax Act.) can own a maximum of 26% of the paid-up equity capital of an Indian insurance company. The law prohibits composites of life with other types of insurance (e.g. liability, fire); health insurance can, however, be sold with life insurance or with general insurance and can be provided to individuals or groups.

A cooperative society registered under the Cooperative Societies Act 1912 can operate life insurance or general insurance under State regulation (not federal). Cooperative societies, mutual insurance companies and provident societies are allowed to provide insurance as non-profit organizations. They are explicitly mentioned in the Insurance (Amendment) Act 2002, which integrated the IRDA Act (1999) with the Insurance Act (1938).

There is some opaqueness in the Insurance Amendment Act 2002 regarding cooperative societies. Section 2, subsection 8A, stipulates that on matters of capital requirements and foreign ownership, cooperatives registered on or after the commencement of the Insurance (Amendment) Act 2002 must comply with the conditions applying to insurance companies under the Companies Act. However, Section 96 of this act explicitly states that the (huge) paid-up capital requirements for registration and capital deposits do not apply to mutual insurance companies and cooperative life insurance societies.

The following sections discuss the regulatory implications of insurers operating under the Companies Act, as provident societies, and as mutuals or cooperatives.

### *Insurance Companies Operating under the Companies Act*

Every insurer must register with IRDA. Four registry actions exist: application, annual renewal, modification or cancellation. The fee to register (different from the paid-up equity capital mentioned below) is a maximum of Rs. 50,000 (\$1,136) per insurance class. The annual renewal fee is 0.25% of the gross premium written per insurance class or Rs. 50 million (\$1.14 million) per class (whichever is less) with a minimum of Rs. 500 (\$11).

The IRDA regulates the following operational issues:

- Conditions of insurance contracts (standards for premiums, terms and conditions that can govern the relations between policyholder and insurer);
- Management (quality, remuneration, conflicts of interests);
- Intermediaries (registration, code of conduct, quality). Maximum length of contract is 10 years, beyond that period a new contract is necessary. The Authority may alter these regulations in case of cooperatives or mutuals acting as agents/chief agents.
- Permitted forms of holding/investing funds and assets (s. 27A Insurance Act). The list contains e.g., government securities, municipality securities (permitted by the state government), first mortgages on immovable properties situated in India under any housing or building scheme condition, preference shares of any company on which dividends have been paid for the five years immediately preceding, loans of life interest, shares in cooperative societies;
- Solvency margins; and
- Accounting and reporting (insurers and insurance intermediaries).

**Rural and social obligations.** Under its development agenda, the IRDA also requires specific investments in the rural and social sectors. To comply with the rural requirements, insurers must sell a minimum level (quota) of their total portfolio (see Table 1.2).

**Table 1.2 Rural and Social Obligation Quotas**

Life Insurance	General Insurance
5% in the first financial year of the insurer's operation	2% in the first financial year
7% in the second financial year	3% in the second financial year
10% in the third financial year	5% thereafter
12% in the fourth financial year	
15% in the fifth year	

In addition, every insurance company (both life and general) must sell at least a predefined number of insurance policies to persons in the social sector, which includes people in the informal economy and economically vulnerable classes. The requirement begins with 5,000 lives in the first financial year and increases steadily to 20,000 lives in the fifth year.

**Capital requirements.** An application for life insurance or general insurance registration will be considered only with deposit of a paid-up equity capital of one billion Rupees (about \$22.7

million). An application for reinsurance registration will be considered only upon deposit of a paid-up equity capital of two billion Rupees (about \$45 million). Valuation of assets and liabilities is prescribed by IRDA.

The following deposits (additional to the paid up equity capital required for registration) must be held with the Reserve Bank of India (RBI) in cash and/or approved securities (RBI determines the market value of securities deposited under this Act):

- Life insurance: 1% of total gross premium written, not exceeding Rs. 100,000,000 (\$2.3 million);
- General insurance: 3% of total gross premium written, not exceeding Rs. 100,000,000 (\$2.3 million)
- Reinsurance: Rs. 200,000,000 (\$4.5 million)

Every insurer must have, in excess of liabilities over assets, a required solvency margin, defined as follows:

- Life insurers: Rs. 500,000,000 (\$11 million) or a function of reserves and reinsurance (for details see Act).
- General insurance: the highest of Rs. 500,000,000 (\$11 million), or 20% of net premium income, or 30% of net incurred claims.
- Reinsurance: Rs. 1 billion (\$22.7 million)

IRDA may direct that the lower of the above-mentioned values may apply in case of an unfavourable claim experience, or because of a sharp increase in business volume, or for any other reason.

**Reporting.** Every insurer must submit a balance sheet, profit-and-loss account, revenue account, and profit-and-loss appropriation account on an annual basis in formats prescribed by IRDA. Every insurer shall keep separate accounts related to funds of shareholders and policyholders.

**Auditing.** An external auditor must audit the accounts of every insurer annually. For life insurance, an actuarial report is compulsory annually and follows a standardized format with statements of the internal principal officer that the assured rates, terms and conditions are actuarially sound.

### *Provident Societies*

Only public companies or registered cooperative societies can offer insurance as provident societies. They are eligible to insure birth, marriage or death (other conditions prescribed by section 65 of the Insurance Act) with a benefit of an annuity payment of maximum Rs. 100 (\$2.30), payable for an uncertain period, or a gross sum of maximum Rs. 1,000 (\$23) (all policies for one person are considered one policy for all contingencies mentioned).

Registration is compulsory in a format prescribed by IRDA. The registration fee for annual renewal does not exceed Rs. 200 (\$4.50) and varies with the volume of insurance business written. The operation of provident societies is regulated by IRDA (e.g., in terms of premium rate, contributions, maximum amount payable to a subscriber or policyholder, mode of payment, benefits, renewal, by-laws, and raising additional capital).

**Working capital** of a provident society needs to be at least Rs. 5,000 (\$114), exclusive of paid-up capital deposited at registration, which is another Rs. 5,000 (\$114). An annual addition in the deposit is required of at least one-fifth of premium income (including fees received by the society) up to a maximum deposit of Rs. 50,000 (\$1136). Deposits are held at RBI, for and on behalf of the central government.

**Reporting.** When more than one class of insurance is offered, separate accounts and funds must be held for each class. Registration of annual income and expenses is compulsory, in the format prescribed. Provident societies must prepare a revenue account and balance sheet with details of new policies affected, total premium income received, total amount of claims made and the expenses. The auditor will then verify this in a prescribed manner. The audit by an internal and external auditor, as well as by the authority, is annual. An actuarial report is compulsory once every five years or less when deemed necessary.

#### *Mutual Insurance Companies and Cooperative Life Insurance Societies*

A “Mutual Insurance Company” is an insurer, incorporated under the Companies Act 1913 (No 7, 1913), with no share capital and whose policyholders are all members. A “Cooperative Life Insurance Society” is a society, acting as life insurer, with no share capital on which dividend and bonus is payable, registered under the Cooperative Societies Act, 1912, or under an Act of state legislature. Cooperatives are licensed to operate under state regulation that prevails over the Insurance Act. Other cooperative societies may be approved as members of a cooperative life insurance society without being eligible for any dividend, profit or bonus.

The capital requirements for a mutual company or cooperative society are only Rs. 15,000 (\$340). Deposit for both types of insurers, when operating life insurance: Rs. 200,000 (\$4545) in cash or approved securities (day-value), deposited with RBI (may be in instalments with an initial deposit of more than Rs. 25,000 (\$568) and an annual addition of more than one third of premium income).

Reporting of the balance sheet and the revenue account has to be submitted with a summary in a prescribed format. This reporting of cooperatives and mutuals is to State Registrar of Companies. This is the State (and not the federal) Registrar under the provisions of Section 134 of the Indian Companies Act 1913. Documents may also be furnished to the registrar of Cooperative Societies of the State in which the Cooperative Life Insurance Society is registered. Auditing is not explicitly mentioned.

#### *Institutional Options*

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 18<sup>th</sup>, 2004, issued by IRDA) promotes the partner-agent model when increasing coverage for the rural population through such schemes. In a recent Round Table with the IRDA in Hyderabad (February 19<sup>th</sup>, 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., NGOs) are allowed to tie up with one life and one general insurance company. 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: each agent should receive at least 25 hours of training at the expense of the insurance company. 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.

**Table 1.3 Regulatory Status of Selected Health Care Financing Schemes**

Health Financing Schemes	Legal Regimes	Regulator
Private Commercial Health Insurance	Commercial law, Insurance Act 1938 and IRDA Act 1999 and regulations	IRDA
Public Sector insurance companies: (a) Commercial competitive: (b) Subsidized non-competitive.	Own Acts: and Insurance Act 1938	(a) IRDA (b) Central Government, Ministry of Finance (subsidies)
ESIS (social security schemes that include health care).	Own Act	Ministry of Labour
Corporate self health insurance	Commercial law	Unregulated
Community-based health insurance	Associations law, cooperatives law	Unregulated. Some subsidies by the Ministry of Finance entail hidden regulation.
Exempted schemes (Calcutta Hospital and Nursing Home Benefit Association)	Own legal status not affected by the Insurance Nationalization Act	IRDA

*Adapted from Cahill & Matthies 2005*

## 1.2 Insurance Industry Basics

In 1956, all 245 companies in the Indian life insurance market, including local and foreign insurers as well as provident societies, were nationalised and combined to form the Life Insurance Corporation of India (LIC), which became a state-run life insurance monopoly. This procedure was repeated in the general insurance market in 1972 when 107 insurers, including branches of foreign companies, were integrated into the state-run General Insurance Corporation (GIC). The GIC later divided the market among its four regional subsidiaries:

- National Insurance Company (NIC) based in Calcutta, largely responsible for the east;
- New India Assurance Company (NIA) based in Mumbai, mainly responsible for the west;
- Oriental Insurance Company (OIC), based in New Delhi, responsible for the north; and
- United India Insurance Company (UIIC), based in Chennai and responsible for the south (Ellis/Alam/Gupta 2000).

As of 1999, private providers again have access to the market if they are Indian companies or were founded as joint ventures with a maximum of 26% foreign ownership. The liberalisation of the insurance market resulted from an increased orientation towards a market economy and became inevitable after India joined the WTO (Bhat/Mavalankar 2000).

The 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. However, the



subsidiaries still coordinate policy baselines in a committee of state-run insurance groups, the General Insurance Public Sector Association (Swain 2000).

To date, besides the four state-run companies, the Export Credit Guarantee Corporation and Agricultural Insurance Company, eight private insurance companies are registered in general insurance. Since the private insurers are reluctant to enter the health sector, the state-run companies still dominate the market. On average, health insurance has grown at a rate of 40% in the three years following 1999 and therefore is the fastest growing segment in the general insurance market. It is expected that health insurance will become the second largest general insurance class after motor insurance (The Economic Times of India 2002).

### *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 insurers since 1986. Mediclaim reimburses the costs of hospital stays and home care up to an individually determined sum (Bhat/Mavalankar 2000). Pre-existing diseases and AIDS are excluded from coverage (Gumber 2002).

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). Like premiums paid to private insurance companies, the Mediclaim premium is income-tax deductible (Ranson/Jowett 2003). The state thereby subsidises 20-40% of the premium (Bhat/Mavalankar 2000). Mediclaim policies are available for individuals, families or groups. Depending on group size, considerable premium discounts are offered (Gumber 2002). For instance, a large employer who insures over 50,000 employees can receive a group discount of 30% plus a commission of 5%, i.e. an overall reduction of 35% (Krause 2000).

Benefits are paid as reimbursements of submitted prepaid bills (Ellis/Alam/Gupta 2000). The patient is free to choose a health care provider as long as certain requirements are met, such as a minimum number of beds.

Following the example of private providers, the state-run insurers have recently begun to use Third Party Administrators (TPAs) to service their clients. They look after policyholders, guide them in choosing services, and pay for the services on behalf of the insurer, thereby enabling the client to receive a cashless service. TPAs are profit-seeking companies that entered the recently liberalised market at the intersection of insurers, clients and health care providers. Besides counselling policyholders, on behalf of insurance companies TPAs monitor health services and billing by keeping in close contact with health care providers (IRDA 2002). They also have to register with the IRDA.

The Mediclaim product, which was used by 10 million Indians in 2004/05 (Cahill/Matthies), does not yet perform in a cost-effective way for the insurance companies (Gumber 2002). Claim settlement rates and administration costs result in loss rates of 130-140% (Nagendranath/Chari 2002), casting doubts on the long-term sustainability of Mediclaim in the face of increasing competition for middle and higher income groups. Variations of Mediclaim, such as a travel health insurance or the Unimedicare policy for lower and middle-income groups offered by the UIIC, were introduced to help the state-run companies penetrate the health insurance market.

Another product in this loss-prone line of business is the **Jan Arogya** policy—400,000 policyholders have this smaller variant of Medyclaim (Krause 2000). From an accounting perspective, it is treated as a branch of Medyclaim for poor population groups. Jan Arogya is one of the most important health insurance schemes for low-income groups. The insurance can be contracted for individuals or groups. As in the case of Medyclaim, the benefits of the Jan Arogya Bima policy are limited to hospital stays with an annual limit of Rs. 5,000 (\$113) to be reimbursed upon submission of the bills. The premiums are age-dependent and range between Rs. 70 (\$1.60) and Rs. 140 (\$3.20). Children under 25 years of age can be co-insured for Rs. 50 (\$1.10).

In 2003, on an initiative by the Minister of Finance, state-run insurance companies introduced a health insurance product that is supposed to protect five to ten million policyholders in the near future. Private insurance companies may participate, but this is unlikely to happen. The so-called **Universal Health Insurance** is offered for Rs 365 rupees 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 of Rs. 264 (\$6) income per person per month received a subsidy from the central government (Social Security Fund) of Rs. 100 (\$2.30) per year per insurance policy. This subsidy was recently increased to Rs. 200 (\$4.60) for a single person, Rs. 300 (\$ 6.80) for a family of five and Rs. 400 (\$9.10) for a family of seven. The product was initially set up as a group policy insuring groups of more than 100 families. At the end of March 2004, 417,000 families comprising of 1.16 million individuals were covered (Gupta 2005).

The coverage provided by this insurance product is always the same, no matter if it was acquired for an individual or a family with five or seven members. Costs of hospital stays are covered up to a total amount of Rs. 30,000 (\$341) per year for all family members (so-called “family floater”). A single hospital stay must not exceed Rs. 15,000 (\$682) (Ahuja 2004).

If the person designated in the policy as the primary income-earner stays in hospital for more than three days, sickness benefits of Rs. 50 (\$1.10) per day are paid as a compensation for lost income for a maximum period of 12 days. In case of accidental death of the primary income-earner, the surviving dependants receive a lump-sum payment of Rs. 25,000 (\$568).

The LIC also supplies a product on the health insurance market called **Asha Deep II**. This product is targeted at major diseases, such as cancer, and provides a lump-sum payment when the illness occurs. Asha Deep II is limited in duration to periods of 15, 20 or 25 years. The percentage of benefits paid upon occurrence of damage depends on the amount of premiums paid up to that point. Due to its restriction to four severe and costly diseases, this insurance product should be regarded as a supplement to other health insurance policies (Gumber/Kulkarni 2000).

Besides state-run insurance companies, private companies also offer health insurance products. The Indian health insurance market is considered to be rather unsaturated. According to estimates, only 10% of the market has been explored, for reasons illustrated in Box 1.1.



### Box 1.1 Hindrances in the Development of the Health Insurance Market

Health insurance is insufficiently served. Total health premiums in the year 2002-2003 have been estimated at Rs.12.8 billion (\$290 million). It is poised to become a Rs. 250 billion (\$5.7 billion) industry by 2009 and treble itself in the next ten years. Though this sector has the potential to grow, there are major obstacles to growth according to a FICCI survey of formal insurers.

According to 65% of respondents, the lack of development of health insurance is due to the absence of database from which insurers can design health products (the IRDA has since taken the responsibility to build such a database). Sixty-one percent identified a lack of product variety—health insurance is not just Mediciclaim. Infrastructure problems were also endorsed by 52% of FICCI survey respondents. The lack of standardisation of healthcare provision was seen as a deterrent to growth for 30% of the respondents, who are interested in seeing better coordination between various agencies, such as the Ministry of Health and the healthcare professional association. Twenty-two percent of the respondents were of the view that capital norms need to be reviewed, as this was also a barrier to growth. (Note: Respondents have indicated more than one choice; the results are therefore not mutually exclusive.)

Though health insurance falls under non-life insurance, there is a view that it will be more effective if health was a part of the life sector, as the two are more related. This view was endorsed by 52% of the respondents. As it is, life companies are making innovative products with health covers as riders, which shows their keenness to enter this sector.

To promote the growth of this sector, TPAs were established. Third party administrators assist insurers in rendering an effective service based on their specialized knowledge and expertise in this sector. Earlier, TPAs had some teething problems, but 52% of the survey respondents were of the view that a TPA network has finally been established in India. However, 39% of the respondents were of the view that TPAs have not helped in improving the Mediciclaim expense ratios.

Some of the suggestions of the insurance companies to create an appropriate health insurance framework in the country were:

- Create a platform for sharing information
- Find the niche markets and have the right product mix through add-on benefits and riders
- Introduce independent health insurance regulation separate from life and non-life. Hospitals should be empanelled with single regulator with fixed pricing
- Make health insurance mandatory up to sum assured of Rs. 100,000 (\$2,273) for all citizens
- Develop a health care cost index for the country.
- Promote group health insurance schemes for Below Poverty Line (BPL) and rural populations with government subsidies and service tax waivers.
- Conduct awareness seminars on health insurance
- Allow specialized health insurance company
- Introduce family coverage

*Adapted from FICCI Survey 2004*

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 approaches or health care service providers (Ellis/Alam/Gupta 2000). As shown in Table 1.4, these employer-based systems, offered by the postal service or railway for example, are estimated to insure 20 to 30 million persons.

**Table 1.4 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
ESIS	31,050
Government Non-Life Insurance Companies	56
Non-Government Non-Life Insurance Companies	13
Employer sponsored	30,000

*Cahill/Matthies 2005; figure for UHI: Gupta 2005*

**Table 1.5 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	<ul style="list-style-type: none"> <li>Valuation of assets and liabilities is done in the prescribed format of IRDA to calculate the required solvency margin.</li> <li>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.</li> <li>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</li> </ul>
Other key requirements for regulatory compliance	<ol style="list-style-type: none"> <li>Companies have to comply with the Solvency margin ratio.</li> <li>Accounting and Reporting to IRDA is done annually with respect to balance sheets.</li> <li>Companies must comply with social and rural sector obligations</li> <li>Companies must comply with investment regulations.</li> </ol>
Minimum capital requirement for reinsurer	Rs. 2 billion (\$46 million) for reinsurance business
Annual premiums of regulated private insurers (2004-05)	<ul style="list-style-type: none"> <li>Rs. 55.6 billion (\$1.3 billion) for 13 life insurers</li> <li>Rs. 35.5 billion (\$806 million) for 8 general insurers</li> </ul>
Annual premiums of regulated public insurers (2004-05)	<ul style="list-style-type: none"> <li>Rs. 197.9 billion (\$4.5 billion) for 1 public life insurer</li> <li>Rs. 140.5 billion (\$3.2 billion) for 4 general insurers</li> </ul>
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. 41.63 billions (\$946 million) (figure for GIC only in 2003/04)
Certification requirements for agents	Rs. 250 for renewal or issue of license 12 <sup>th</sup> grade standard passed 100 hours practical training

### 1.3 The Role of the State in Social Protection

The Employee State Insurance Scheme (ESIS) founded in 1948 is another provider of formal insurance, functioning as a social health insurance scheme. ESIS is obligatory in certain industries when a certain number of employees are exceeded. The system is financed by contributions collected as a percentage of the gross wage. Employees pay 1.75% of their wages in contributions, while the employer adds 4.75%. The Indian states subsidise the system with general taxes.

Administered by a state corporation, Employees State Insurance Corporation (ESIC), this scheme covers illness, motherhood, disability and death from work accidents. ESIS runs a network of health care service providers consisting of individual physicians as well as hospitals. The services range from prevention and health counselling to curative treatment and rehabilitation. With 8.5 million members, ESIS covers 33 million individuals in 22 Indian states. However, ESIS is not unopposed. Some companies try to avoid the obligatory insurance or supplement it with their own service offers (Ellis/Alam/Gupta 2000). The system is blamed for management weaknesses and poor service provision. Another problem is that ESIS health service providers are not working to full capacity.

For central government employees and their dependants, health care services are provided through the Central Government Health Scheme (CGHS). Introduced in 1954, the system is provided by the government for its employees, i.e. people receive health services without paying contributions (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). Like ESIS, this system is blamed for inadequate and inefficient services.

### 1.4 Brief Profile of Microinsurance

India is a hot spot for the development of microinsurance. Many micro-schemes have emerged in recent years, but there are some older schemes as well. The fast development of the microinsurance might be due to two reasons:

1. All companies that operate in India must dedicate a fraction of their business to the low-income market. Few companies regard the rural and social obligations as a business opportunity. Nevertheless, the number of policies with poor customers increases with increasing penetration of the higher-income market.
2. India has a successful history with self-help groups in the area of microfinance. Many microfinance institutions have set up schemes to serve their clients. Other community-based organizations have taken the same path, leading to the development of stand-alone community schemes in which a growing number of people are covered.

Government and the regulating authority acknowledge that insurance can be a risk management mechanism for the poor. Therefore, rural and social obligations for the formal insurance companies were introduced, which has led to the widespread use of the partner-agent approach, although other models of insurance provision exist as well. Some insurance products of the formal (public) insurance companies are subsidised by the government.

## 2. The Institution

### 2.1 History of the Institution

In 1981, Dr. Sudarshan founded Vivekananda Girijan Kalyan Kendra (VGKK) to work with the Soliba tribal population of BR Hills (see Box 2.1). Later, VGKK extended its geographical area of operation to Yelandur, Chamrajanagara, Kollegal (including MM Hills) and Nanjangud taluka<sup>11</sup> in Karnataka. In 1987, Dr. Sudarshan founded Karuna Trust (registered as a charity), which is dedicated to rural development and rural health. The trust operates fifteen primary health centres and reaches at least 275,000 people. It is still affiliated to VGKK and Dr. Sudarshan is still the driving force behind both organizations.

Karuna Trust has four operational areas: 1) health programmes, e.g. ambulance, diet services and cancer awareness; 2) community development, which includes self-help groups and microfinance, as well as organic farming and vocational training; 3) education, e.g. schools are adopted to improve quality of teaching and community participation among other things; and 4) spiritual empowerment of the rural poor.

Karuna Trust follows a holistic, democratic, decentralised and participatory approach to rural development that takes into account cultural and regional differences and aims for the empowerment of every individual. Karuna provides essential knowledge and skills to lead a healthy life. People are empowered to solve health problems of the community and the family by themselves. Primary health centres focus on community-oriented preventive medicine, instead of a top-down approach.

The organisation was founded during a time when Yelandur taluk was hyper endemic in leprosy. Initially, Karuna was operating exclusively to reduce leprosy infections. By the end of 1987, the trust concluded its limited Leprosy Eradication Programme successfully. In the following year, the state government of Karnataka passed the responsibility of running the programme for the entire taluk to Karuna. For the first time, the trust took over responsibilities from the state; many more co-operations followed. Karuna implements activities in lieu of the state and receives some financial support in return. In 1990, the main aims of the leprosy programmes were reached and Karuna turned to other neglected areas in health. Henceforth, Karuna Trust's health programmes were expanded:

- In 1990, the trust focused on a control programme for **epilepsy**. Ninety-eight percent of patients can be effectively treated with two inexpensive drugs. Free treatment can therefore be given to all registered patients in the taluk.
- **Tuberculosis** control was started in 1992. After receiving the full treatment, more than 85% of the patients were cured. Training for health workers, lab technicians and medical officers by the National Tuberculosis Institute supports high-quality treatment.
- Karuna Trust follows a community-based approach for treatment of **mental illness**. In rural areas, the lack of awareness as well as a lack of social welfare support worsens the

<sup>11</sup> A taluk (pl.: taluka) is an Indian local entity. A number of taluka make up a district.

situation for patients. An emphasis is set on the training medical officers and health workers in diagnosing and treating mental diseases.

- Community-based eye care program strives to prevent **blindness** by supplying Vitamin A, especially to children. Another main focus is on the early diagnosis of cataracts and the support of patients who undergo a cataract surgery. Multipurpose workers and medical officers also develop their knowledge to treat eye infection and injuries.
- **Dental health** is neglected in some rural regions, but it is an important health concern. Karuna Trust operates a fully equipped mobile dental health unit. At fixed times it makes dental care available at primary health centres. Furthermore, dental checkups for schoolchildren are conducted and health workers are trained in dental health.
- An **Herbal Medicine** Production Unit encourages villagers to grow herbs. Some self-help groups have started to plant 'Adotoda Vasaka' and other herbs. In Mysore, a training centre with an herbal garden was opened in July 2005.
- The Trust also runs 18 **Primary Health Centres** in 16 taluka on behalf of the government. The State Government seems to be quite satisfied with the Trust's management. Further Primary Health Centres are handed over to Karuna.

Karuna Trust expanded its work to T. Narsipur Taluk in 1996 in collaboration with Dr. Nagaraju Family Charitable Trust. The health and community-based rehabilitation programme are part of broad socio-economic activities. Sustainable agriculture, low-cost housing, social forestry, tribal cooperatives and promotion of appropriate technology, school adoption, economic and human resource development programmes are further activities that point out the wide variety of Karuna Trust's initiatives.

#### Box 2.1 Dr. Hannumappa Reddy Sudarshan

Dr. H. Sudarshan was born in 1950 in Bangalore and graduated as a doctor in 1973 from Bangalore Medical College. He decided not to practice in a lucrative urban area, but to dedicate his life to social development of poor communities. In 1979, he started to work with the Soliga tribe that has lived for centuries in the B.R. Hills of Karnataka in harmony with nature. Deforestation for industrial purposes deprived the tribe of their natural existence. Even governmental programmes to modernise villages in Karnataka did not benefit Soliga villages. When Dr. H. Sudarshan set up a clinic in 1979, he realised that the Soligas had no access to water, electricity, health care and schools.

He founded VGKK in 1981 to provide development mechanisms to the Soligas. Within 20 years, the situation of the Soligas' has improved immensely. From being oppressed and unprivileged, the tribe has become empowered. They have a strong community now that protects their rights, enables them to participate and to become self-reliant and makes sure that their close relationship to nature and traditions does not suffer.

Among a variety of awards, Dr. H. Sudarshan received the Right Livelihood Award in 1994 "for showing how tribal culture can contribute to a process that secures the basic rights and needs of indigenous people and conserve their environment."

#### *The Microinsurance Operations*

In collaboration, the Indian Ministry of Health and UNDP conducted studies across India on improving the health status of the rural and poor population. One of the recommendations

was community health financing. A feasibility study screened existing experience and different models of insurance provision. As a result, it was decided to set up pilot schemes in West Bengal and Karnataka to test community health financing options and to learn from the experiences. It was agreed to partner with established and successful NGOs. Recommended by the Government of Karnataka, Karuna Trust was approached in 2001.

The preparation of the actual insurance operations took about one year. Centre for Population Dynamics (CPD), a research institution already well known to the Government of Karnataka, and Karuna Trust were asked to conduct the baseline study. On initiative of the state government, the scheme was designed to focus only on the public health centres. Karuna Trust's microinsurance operations started in 2002. To overcome the market's lack of knowledge about insurance, UNDP agreed to subsidize the premium. A second, similar, insurance scheme was initiated in Bailhongal taluk using public infrastructure instead of an NGO like Karuna Trust.<sup>12</sup>

National Insurance Company Ltd., a public insurance company, agreed to provide the insurance package. Concerned about potentially high claim load, a maximum claim ratio of 150% was agreed and a Memorandum of Understanding (MoU) was signed with Karuna Trust. Claim ratios above have to be borne by Karuna Trust.

**Table 2.1 Insurance Organisation Basics**

Issues	Observations
Legal structure	Registered Charitable Trust; NIC is regulated insurer
Registration status	Registered in 1987
Start of corporate operations	1987
Start of microinsurance operations	2002
Core business	Holistic approach in rural development with special focus on health and economic development
Target market – core business	All poor households in the taluk. Currently, Karuna Trust serves 40,000 families (52% of population) in T. Narsipur Taluk with one of its operations.
Target market – insurance business	Same as core business but for some households regarded as “ultra poor” other solutions are discussed
Geographic area of operation	T. Narsipur taluk, Yelandur taluk (both in Karnataka)
Development, marketing, or servicing policies with other institutions	NIC (insurance provider), UNDP (supportive funding), Centre for Population Dynamics (development), (local) Government of Karnataka structures (provision)
Reinsurance provider, provider type	None

Karuna Trust is registered as a charitable trust eligible for tax exemptions under the Indian Trust Act of 1851, which means that it should benefit a target group like scheduled caste, scheduled tribe, other backward classes, or women and children.<sup>13</sup> The trust's objective should be consistent with the definition of the term “charitable purpose,” which includes

<sup>12</sup> This case study focuses on Karuna Trust's experience in the T. Narsipur health insurance scheme only.

<sup>13</sup> The hindu caste system distinguishes four main castes: Brahmins, Kshtriya, Vashiya and Shudra. The Shudras, the lowest caste, generally work in low paying professions like cleaning, shoe making etc. They are scheduled or listed in the constitution of India (therefore “scheduled caste”) to be eligible to receive special benefits. The same is true for scheduled tribes, the indigenous populations of India, which are usually disadvantaged in their daily life as well.



relief for the poor, education, medical relief and the advancement of any other object of general public interest.

No income generated in the trust should 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. There is no central law governing public charitable trusts although most states have “Public Trusts Acts”. Typically, a public charitable trust must register with the office of the Charity Commissioner having jurisdiction over the trust in order to be eligible to apply for tax-exemption.

**Table 2.2 Insurance Organisation Basics - Trends**

	2005	2004	2003	2002
Total assets (US\$)	*	*	*	*
Annual budget (US\$)	**	**	**	**
Total capital (US\$)	11,360	11,360	11,360	11,360
Number of branches	4	4	4	4
Total number of microinsurance policyholders (heads of households)	~ 6,000	~ 14,000	~ 7,000	~ 18,000
Total number of microinsurance insured lives	26,530 <sup>a</sup>	61,233	33,716 <sup>b</sup>	85,092
Number of microinsurance staff	~ 40 <sup>c</sup>	~ 40 <sup>c</sup>	~ 40 <sup>c</sup>	~ 40 <sup>c</sup>
Number of policyholders / microinsurance staff (%)	663,25	1530,82	842,9	2127,3
Microinsurance marketing costs (US\$)	-	-	-	2,730

\* The insurance scheme per se owns no assets.

\*\* There is no special budget for microinsurance operations.

<sup>a</sup> Premium collection is still going on; Karuna Trust decided to insure several batches this year per July 20<sup>th</sup>, July 28<sup>th</sup>, October 5<sup>th</sup> (these three account for 26,530 lives) and December 15<sup>th</sup> (Karuna expects to reach 50,000 insured after the fourth batch).

<sup>b</sup> Chamarajanagar taluk (separate operation from 31<sup>st</sup> March 2003 until 29<sup>th</sup> Feb. 2004), premiums subsidized at 100% as only BPL SC/ST people were covered; In T. Narsipur the insurance was reintroduced on 1<sup>st</sup> June 2004 with Chamarajanagar as extension of T. Narsipur operations from this year onwards.

<sup>c</sup> Not all work full time for the insurance scheme

## 2.2 Organisational Development

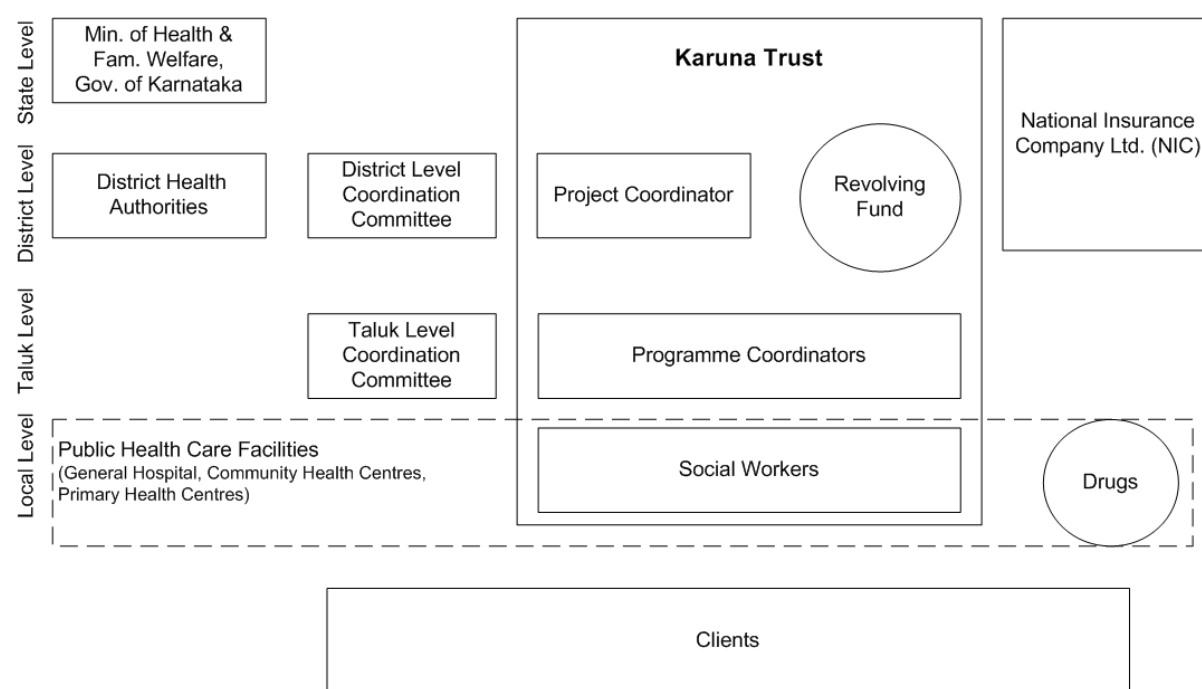
### *Strategic Structure*

Karuna Trust follows a partner-agent model of insurance provision while making use of the public health infrastructure. With its product, Karuna Trust compensates for some of the public infrastructure’s shortcomings. The structure of this arrangement involves various organizations at the state, district, taluk and local levels, as illustrated in Figure 2.1.

The Karnataka Ministry of Health and Family Welfare is involved in the strategic planning at the state level. The subordinate **Health Authorities** (e.g., Zilla Panchayat Health Officer) attend meetings of the **District and Taluk Level Coordination Committee**. Representing the health care provider in this insurance arrangement, they are expected to improve the quality of health care services. The coordination committees meet regularly and monitor the implementation of the insurance scheme. Members of the coordination committees include the executive officer of the respective Panchayat, medical professionals of health facilities in the area, as well as representatives of Karuna Trust and NIC.

Karuna Trust partners with National Insurance Company, a public insurance company. In terms of gross direct premium collected, it holds about 20% of the Indian general insurance market. Like all four public general insurance companies, NIC grants a good proportion of the decision power to its regional offices. NIC’s regional office in Bangalore is responsible for the strategic part of the insurance operations of Karuna Trust, such as negotiating the product specifications with Karuna. Although their headquarters takes the final decision, one can assume that the regional office’s support is at least half the way to a new product. In the case of Karuna Trust, NIC’s Bangalore office reviews the claim ratios, negotiates the terms and conditions for modifications, as well as decides on the premium charged. Members of NIC’s regional office also participate in the biannual meetings of the District Level Coordination Committee.

**Figure 2.1 Organisational Structure**



*Operational Tasks*

The divisional offices of NIC, one level under the regional office and usually located in the district capitals, are responsible for the back office operations in the cooperation with Karuna Trust. For example, the Mysore divisional office is responsible for Karuna Trust’s operations in their district. It receives the lists of people insured and their premiums paid once a year and settles claims on a weekly basis. The divisional office also prepares the statistics for NIC.

The front office operations, carried out by Karuna Trust, are integrated in the structure of Karuna’s non-insurance activities. Strategic planning is mainly carried out in the trust’s headquarters in Bangalore. Strategic planning is done in close interaction with the operational level and also grassroots information is utilized. Decisions to negotiate for changes in the benefit package are mainly taken here.



The implementation of the insurance activity is supervised and managed by the **Project Coordinator**, who holds a Master's degree in Sociology. He is responsible for implementing all health and community development activities at Karuna; about 40% of his time is dedicated to the insurance project. The project coordinator ensures the flow of information among his field staff. In monthly meetings, he informs all involved staff about changes in the product, the progress made, discusses problems and sets operational targets. He is responsible for managing the revolving fund together with the office manager placed in T. Narsipur office (see below). The project coordinator ensures adherence to the rules; sometimes he is directly involved in ensuring that clients receive their full benefits.

Next in the hierarchy are the **Programme Coordinators**. In T. Narsipur Taluk, three programme coordinators are placed in the field office to implement Karuna's activities. With the introduction of health insurance, a new coordinator was employed. He spends about 60% of his time on insurance while his two colleagues invest about half of their time. It is their duty to:

- **Supervise the social workers** and check the appropriateness of claims and measures taken by the social workers. They also equip the social workers with an emergency budget from the fund so they can respond immediately when a claim is submitted.
- **Control data entry.** Most of the administrative operations are done by Karuna's field offices. After collecting the premium and issuing a receipt, the names of the clients are entered into an excel sheet formatted by NIC. Two to three assistants upload the data. Karuna keeps the receipts and sends the electronic file to NIC. A claims overview list is prepared for NIC, while the detailed documents remain with the Trust's office. The programme coordinators verify the accuracy of these lists. NIC agrees to these lists on a basis of trust, but reserves the right to verify them.
- **Maintain contact with divisional office of insurance.** Once a week, a programme coordinator visits NIC's divisional office in Mysore. He submits a list of claims and discusses recent topics. Once a year, he also submits the list of clients enrolled.
- **Interface with SHGs.** The programme coordinators communicate with the SHG through the SHG apex structure. Karuna's SHGs are organized into Cluster Development Associations (CDA), which again are organized into a Federation of CDAs. The programme coordinators use their regular meetings with the CDAs and the Federation to discuss insurance. This information can then trickle down to the SHG members.
- **Enrol members.** Enrolling members is a high priority. Starting with the programme managers, everyone is involved in convincing people to join the scheme.
- **Reimburse clients.** The public health care providers in the project area are the designated facilities. However, clients may use all public health providers in the state; this enables them to travel without losing insurance coverage. To claim their benefits in this case, they need to approach Karuna's field office and present their documents to a programme coordinator.
- **Coordinate with health authorities.** The programme coordinators attend the monthly coordination meetings with the health authorities. Problems with the implementation of the scheme are discussed as well as information exchanged.

A **manager** in Karuna's field office has a controlling and backstopping function, particularly for the revolving fund. UNDP set up a Rs. 500,000 fund during the pilot phase to enable immediate reimbursement. The manager regularly withdraws money from the account and hands it over to their social workers. NIC directly reimburses this bank account. He checks completeness of the documents submitted by the social workers after a payment is made to a client before he reimburses the social worker's emergency fund. He can be described as the financial controller in the field. About one fourth of his time is dedicated to the insurance component of Karuna's activities.

Placed in health facilities where inpatient admission is frequent, **hospital social workers** have their own office and work full time on insurance. They maintain an inpatient register (Annex 1) and verify and settle the claims. After a patient is admitted to the hospital, the social worker checks the facility's admission book and verifies the insurance membership of the person through a computer programme designed and provided by NIC.

The social worker maintains a voucher book to record the claim and the money paid to the client (Annex 2). Generally, compensation to the client for wage loss is intended to be paid on a daily basis, although sometimes it is done when the patient is discharged from hospital. To compensate patients for wage loss immediately, the social workers carry Rs. 5,000 (\$114) from the revolving fund as an emergency fund.

One further important task of the social workers is to enrol new members. During the subscription period, the social workers market the insurance scheme—about one third of the clients in the latest renewal round joined in through these social workers. It is agreed with the insurance company that even patients admitted to hospital can still join.

Karuna Trust established a network of **local social workers** at the Gram Panchayat<sup>14</sup> level who are involved in implementing all of Karuna's activities. These social workers attend the SHG meetings. Although the main purpose of the self-help groups is microfinance, they serve as an entry point for the distribution of the insurance product. The social workers explain the concept of insurance and collect the premiums in the groups. Non-SHG-members can approach the self-help groups to join the insurance scheme. The social workers at Gram Panchayat level are the direct link to Karuna Trust.

Only public **health care providers** are eligible in the scheme. Since doctors in T. Narsipur decided not to do the claim verifications and processing for the scheme, social workers were placed there. The doctors interact closely with the social workers; however, in few cases interpersonal problems hinder smooth collaboration.

Certain documents need to be provided by the health facility to guarantee immediate settlements of claims. The most important document is the discharge summary signed by the treating doctor (Annex 3). In the public facilities, Karuna's poor clientele usually get free treatment or only needs to pay a very modest contribution. Table 2.3 summarises the stakeholders' main responsibilities.

<sup>14</sup> Local administrative entity in India; usually covers four to six villages.

**Table 2.3 Stakeholders' Main Responsibilities**

	Conceptual Development	Advertising	Premium Collection	Claim Settlement	Financial Management	Financial Backup	Health Care Provision
Karuna Trust Head office	X						
NIC Regional Office	X						
NIC Divisional Office					X	X	
Health Authorities	X						
Project Coordinator					X		
Programme Coordinator		X	X	X			
Social Worker		X	X	X			
Self Help Groups		X	X				
Health Care Providers							X

### *Insurance Expertise*

The insurance experience of the managers varies. While the staff of NIC has extensive knowledge, the concept was new to Karuna's staff. The staff of Karuna Trust in turn has extensive experience in dealing with the target group. Most middle-level managers at Karuna have master's degrees; most social workers have undergraduate degrees.

The Centre for Population Dynamics (CPD), a private not-for-profit research institution, was involved in the conceptualization of the scheme. Some of their staff members conducted insurance training at the health centres and with the staff of Karuna Trust. The health care providers were the focus of the training with special attention paid to the doctors.

The goal of the training module for doctors was to communicate the purpose and elements of health insurance and their key role in the process. The training made sure that doctors knew the basics about health insurance, how it is applied, and its main advantages. The doctors were encouraged to ensure proper identification of the beneficiary and to document and issue receipts properly. Furthermore, ethical guidelines were given to the training participants.

## **2.3 Resources and External Relationships**

The pilot phase (2002-2004) of the project was implemented by a consortium of five partners: Karuna Trust, UNDP, NIC, Centre for Population Dynamics, and Karnataka's health authorities. UNDP and the Ministry of Health decided to develop a few community health financing pilot schemes and provided about \$450,000 through UNDP. These funds were used to finance the first two years (2002-2004) of the pilot scheme in T. Narsipur, Bailhongal, and the extensions of the schemes to two other taluka. NIC agreed to design a new product for this pilot insurance scheme, designed in collaboration with Karuna Trust and CPD. It was CPD's task to assist in conceptualizing the product and to monitor the implementation. Karnataka's health authorities were involved in matters regarding cooperation with the public health facilities. In Bailhongal taluk – unlike in T. Narsipur – the scheme was fully implemented through the health authorities.

For the first two years, the premium for BPL members and scheduled castes/scheduled tribes (SC/ST) was fully subsidised by UNDP. Some groups (BPL non SC/ST) enjoyed partial (2/3) subsidies in the first year. The subsidised premium amount was transferred directly to NIC. The subsidized pilot scheme ended in 2005; now premiums have to be paid fully by the insured clients. As NIC's agent, Karuna Trust earns approx. 5% (Rs. 1 per policy issued) of the premium to cover its administrative costs. Since this amount is insufficient, Karuna utilizes funds from other activities to cover the remaining costs.

Convinced by the social character of the scheme, NIC agreed to a maximum claim ratio of 150% and cross subsidizes this insurance activity. This cap will be subject to regular review. In case the scheme is expanded to other districts and the numbers of insured grow significantly, NIC might modify this commitment.

## 2.4 Risk Management Products

Karuna Trust offers two risk management products:

1. Health insurance should protect households from falling into poverty due to hospitalisation. By offering compensation for wage loss when hospitalised, Karuna creates an incentive to seek care early. The additional compensation for wage loss in case of surgery (lump sum of Rs. 500 (\$11)) is an incentive for the patient to recover at home for ten days after leaving the hospital. Karuna wants to ensure that being forced to work too early after surgery does not decrease long-term productivity.
2. Besides the insurance, Karuna Trust offers a loan fund to its microfinance groups, which is intended to help in case of outpatient treatment (see Box 2.2).

### Box 2.2 Health Revolving Fund

Outpatient care is not free of cost – even in public facilities where it is supposed to be free. Karuna Trust's beneficiaries report about payments of Rs. 50 to 100 to doctors in public facilities when seeking care. Additionally, drugs often have to be purchased from private pharmacies as they are not available in the public facility (and for OPD not covered in Karuna's insurance programme). Therefore most beneficiaries prefer consulting a private doctor where the drugs needed are covered in the doctor's bill of Rs. 50 to 100.

To respond to this demand, Karuna Trust and UNDP set up a "Health Revolving Fund" which is administered through the microfinance structure of Karuna Trust. All 245 of Karuna's SHGs in T. Narsipur were allocated Rs. 5,000 as additional funds. These funds can be used in addition to the SHGs' own funds for health related issues. The CDA Federation controls the use of these funds as the purpose for loans has to be stated with each loan given to a member. A total of Rs. 1,250,000 (\$28,400) has been transferred to the SHGs' bank accounts.

## 2.5 Profit Allocation and Distribution

The scheme is not designed for profit. All funds are transferred to NIC; in case of a positive balance, the profit would be with NIC.

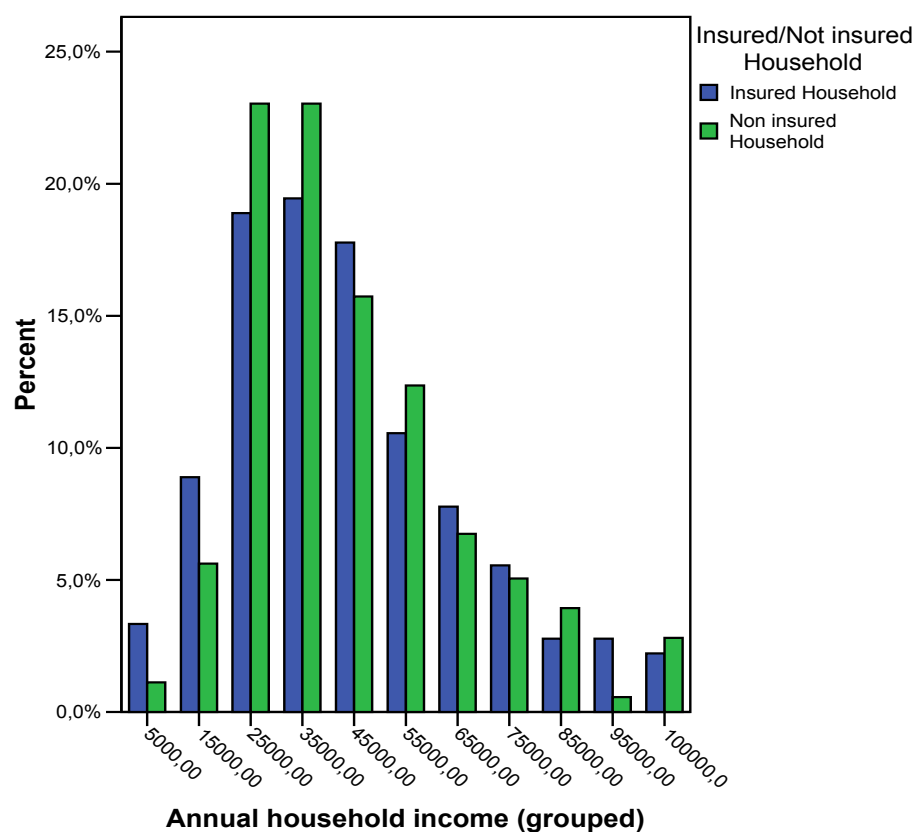
## 3. The Members

### 3.1 Social and Economic Conditions

There are 132 villages in T. Narsipur taluk with a total population of about 240,000. The vast majority of people live in rural areas. According to the 2001 census, 36.1% of the population is younger than 15 years of age. The population aged between 15 and 54 are the main wage earners and constitute 53.2% of the total population. About 10% of the population is 55 years or older. There are more males in the population than females.

Most of Karuna's target group are daily or seasonal labourers. They work in construction or as agricultural labourers and earn around Rs. 30 to Rs. 45 (\$0.70-\$1) a day if work is available. A few own a small piece of non-irrigated land themselves. As shown in Figure 3.1, in T. Narsipur taluk, the median annual household income is Rs. 35,000 (\$872).<sup>15</sup> The main income is earned during the harvest season in September, October and November. During the harvest in May and June, demand for labourers is decreasing and only a few find work.

**Figure 3.1 Annual Household Income Insured and Uninsured in T. Narsipur**



<sup>15</sup> Source: Household survey conducted by the project "Strengthening Micro Health Insurance Units for the Poor in India", July 2005. The survey was funded by the European Union with additional support kindly granted by Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ).

The annual household income is influenced by many factors. The CPD baseline study revealed that the health status of the main wage earner in the family has a huge impact on the household income.

In terms of religion, Hindus account for 92% of the population in the district. Among the Hindus, the SC and ST constitute 12.5% and 4 % respectively. There are 1.4% Muslims and 0.1% Christians. 6.3 % of the population are of other religions.

The educational situation is mostly determined by the analysis of the literacy rate. About 55% of the males and 45% of the females are literate. About sixty percent of the families live in a semi pacca (mud and bricks usually with a roof of coconut palm leaves) house; however, only 22% of the population in T. Narsipur taluk lives in pacca (brick) houses. The average size of a household in T. Narsipur is 4.8 family members. More than 18% of the population are organized in self-help groups (CPD baseline study and 2005 household survey).

**Table 3.1 Client Information Table**

Issues	Observations
Intended target groups/clients	Below poverty line population in three blocks
Actual clients and reasons if deviation from intended market	Little difference; some above poverty line joined
Exclusions of specific groups	Focus is on people around poverty line; those clearly above are excluded
General economic situation of clients	Poor segments of population
Key economic activities of clients	Daily or seasonal labourers
% of clients working in the informal economy	More than 90% (estimated)
Social characteristics of clients	Many scheduled casts and scheduled tribes
Geographic characteristics	Mainly living in T. Narsipur
Nature of membership	Individual contract
Methods of recruitment of clients	Through SHGs or through individual contact

### 3.2 Major Risks and Vulnerabilities

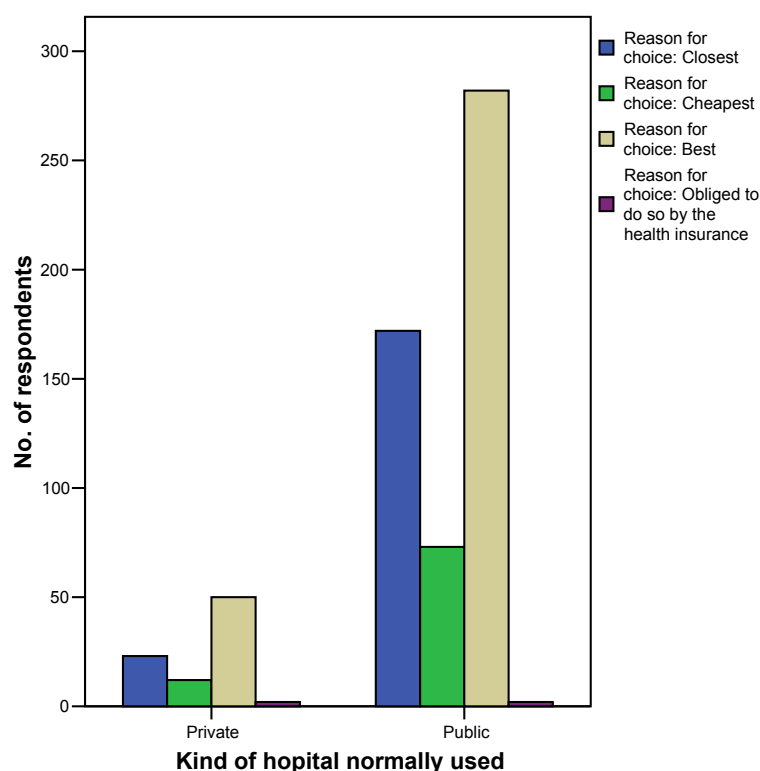
Most of the problems are linked to concerns of livelihood security. Unemployment is an overriding and growing problem—machines replace many agricultural workers in one of the two harvests of the year. Borrowing in self-help groups, from neighbours and moneylenders are typical strategies to maintain consumption. All aspirations focus on livelihood options that assure income security and income accumulation in the long term. The health expenditure is high and threatening, especially for poor families. Ill health is regarded as major cause of poverty. The primary strategy to cope with expenditure on health services—like illness, hospitalisation, maternity expenses, family planning and death—is through borrowing. Selling livestock is the second option in case of hospitalisation. However, for outpatient illness, many use their savings (CPD baseline study; PRAXIS (1999)).

### 3.3 Relationship between Client Risks and the Institution's Services

Karuna addresses many of these problems as it follows a holistic development approach. With focus on health-related spending, the insurance can compensate for loss of income

effectively. By forcing the clients to use the free government services, it may not respond to the clients' preferences, but helps in saving money. The number of private hospitals in the area is limited (travel would be necessary) so that many clients (and non-clients) use public providers and perceive the quality as the best available (see Figure 3.2).

**Figure 3.2 Choice of Hospital (2005 Household Survey)**



For the self-help groups, Karuna Trust provides an additional loan fund restricted to health related use. This is intended to enable the clients to pay for small outpatient treatments independently as these services are not covered.

### 3.4 Familiarity with Insurance

There was very little knowledge about health insurance before the insurance pilot was launched in T. Narsipur taluk. According to the CPD baseline study, 93% of people had no knowledge about health insurance. Even less is known about vehicle, property and fire/theft insurance. The respondents seemed to be more familiar with life insurance, with 29.5% expressing some knowledge about life insurance. Over half of those who knew about insurance before joining got their knowledge from insurance agents or health institutions.

Although the awareness of insurance principles was very low among the total population, it has increased since the start of the insurance pilot. About 40% of the people interviewed in the 2005 household survey (n=358) knew at least roughly what insurance is. But it differs between those who are members of Karuna's self-help groups and those outside of this structure. SHG members have a better understanding about insurance than the general population, which suggests that information flows are better within institutional structures.



## 4. The Product

**Table 4.1 Product Details**

	<b>Product Features and Policies</b>
Microinsurance Type	Partner-agent health insurance product
Group or individual product	Group policy for NIC, individualized by Karuna Trust
Term	One year
Eligibility requirements	Targeted at people around poverty line, living in the areas of operation
Renewal requirements	Premium payment
Rejection rate	No rejection reported
Voluntary or compulsory	Voluntary
Product coverage (benefits)	<ul style="list-style-type: none"> <li>• Rs. 50/day (\$1.10) in case of hospitalisation as compensation of income loss; max for 30 days</li> <li>• Rs. 50/day (\$1.10) in case of hospitalisation paid to special drug fund at the facility used; max. for 30 days</li> <li>• In case of surgery, Rs. 500 (\$11) are paid for compensation of loss of income and Rs. 500 (\$11) to drug fund; restricted to one surgery per person and year</li> </ul>
Key exclusions	None
Pricing – premiums	Rs. 22/year (\$0.50)
Pricing – other fees	-

### 4.1 Partners

With the end of the pilot phase 2002-2004/05, Karuna Trust's partners in providing the insurance are National Insurance Company and the public health authorities.

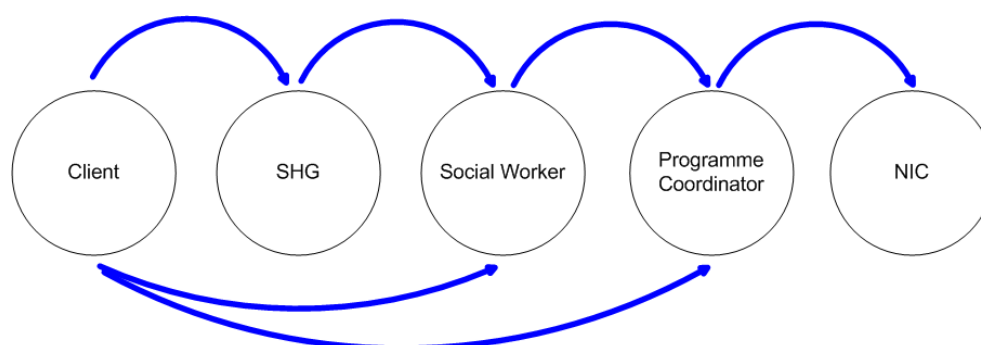
As a public insurer, developing products for the poor is part of NIC's social responsibility and is requested by politicians. NIC bears the financial risk in this partner-agent arrangement and has agreed to a claim ratio of up to 150%. Claims beyond this level are borne by Karuna Trust. NIC's regional office is very positive about the health insurance pilot and interested in improving its performance. For them, the scheme is not only a social obligation imposed by insurance regulations, but a matter of heart. They are keen to learn how products for the poor can work. The relationship between NIC and Karuna Trust seems to be very good.

The public health facilities are the scheme's only designated providers. The health authorities and some doctors participate in the (district/taluk level) coordination committees of the scheme. By participating in the coordination committee, the provider side is directly involved in the scheme's implementation. They are more than simply the supply side of health care.

### 4.2 Distribution Channels

Karuna Trust has implemented an effective distribution mechanism through offering clients a variety of alternative entry points, as illustrated in Figure 4.1.



**Figure 4.1 Distribution Channels**

- Most clients are members of Karuna Trust’s **self-help groups**. These groups disseminate information about the scheme and offer a platform for those willing to join. During subscription time, SHG members can pay their premium directly to the local social worker and receive a receipt (see Annex 4).
- If **non-SHG members** want to join, they can ask an SHG member to forward their request. It will be discussed during a group meeting and in case of a positive decision, the social worker will contact the concerned person. The SHGs check whether the applicant is a resident of the respective village and if the income is sufficiently low, since only BPL households are eligible to join. To confirm BPL status, SHG members are supposed to check the applicant’s ration card (see Box 4.2), but this is usually replaced by social control. By involving the SHGs, Karuna Trust makes use of the information available among the members; but as members are not bearing part of the risk, this mechanism is unlikely to create the desired effect.
- Potential clients also approach the **social workers** in health facilities. In the last subscription period, about one third of the clients in T. Narsipur taluk joined at health facilities. A minority joined when they were admitted. As a social commitment, even these patients are immediately covered.
- During the renewal period, many social workers go house-to-house to inform people about the insurance. This mechanism is time consuming, but seems to be rather effective.
- The programme coordinators serve as an additional distribution channels. In their daily work, they inform people about insurance and prospective clients can approach them at the field offices where they can become a member of the scheme.

The distribution channels seem to be effective as Karuna Trust mainly builds on its existing infrastructure. Using the same infrastructure has the advantage of leveraging the trust that was built up through other activities.

The social workers at the health facilities are a particularly effective channel since they approach prospective clients (or are approached) when the client’s attention is focussed on health issues. They make use of the increased readiness of clients in these situations. The value of the “right” situation when addressing a potential client is acknowledged in product

marketing and Karuna Trust has incorporated this in its marketing; but in case of health insurance, it might lead to adverse selection.

### 4.3 Benefits

The benefits in the health insurance scheme were designed to supplement services for the poor in public facilities. Health care in India is provided by public and private health care facilities, as described in Box 4.1.

#### Box 4.1 Health Care in India

The provision of public health services is divided into primary, secondary and tertiary sectors, which reflect increasing specialisation.

In rural areas, health sub-centres form the institutional basis of primary health care. Each sub-centre is supposed to provide essential services for up to 5,000 individuals (the actual average in 1999 was 4,579) (Planning Commission 2001). Jointly with other institutions, they also provide family planning and other public health programmes (e.g., hygiene and water purity programmes) that are supposed to be carried out by paramedical personnel such as auxiliary nurse midwives (Planning Commission 2001). In reality, however, many positions in the 137,000 sub-centres are vacant (World Bank 2001).

The sub-centres are complemented by community health workers under supervision of the sub-centre. These community members provide essential health care on a part-time basis. A three-month training course is supposed to enable them to perform first aid according to traditional and allopathic principles.

The 23,000 primary health care centres (PHC) are in charge of six sub-centres each. Besides outpatient treatment, most PHCs offer inpatient treatment with four to six beds. According to the plan, each PHC serves 30,000 people and employs one physician supported by 14 staff members (Planning Commission 2001). Although 20% of all hospital beds in India are found in PHCs, only 5% of all hospital days are spent in these centres (Mahal et al. 2001). Apart from inadequate medical equipment, this gap is mainly due to personnel shortages. Nurse positions often remain vacant due to low pay, poor career prospects, and unattractive locations. The same is true for 28% of all physician slots (World Bank 2001). The incumbents of filled positions are often absent from work. Inadequate pay induces many of them to seek a second job (Betz 2002). The budget shortcomings of the PHCs not only affect personnel and capital goods (medical equipment, furniture, buildings), but also consumer goods such as pharmaceuticals. The budget for outpatient treatment is short by 45% (Ashtekar 1999).

The secondary sector of the Indian health care system consists of rural hospitals and community health centres (CHC). Serving four PHCs, the CHC's specialised medical services are intended for 120,000 people (Government of Maharashtra n.d.). In 1999, 3,000 CHCs served 214,000 people each. For several years now, there have been plans to upgrade 2,000 CHCs to the status of regional hospitals (Planning Commission 2001).

Community health centres are supposed to have at least 30 beds, an operating theatre, a laboratory, x-ray facilities, as well as a team of four medical specialists and a support staff of 21. This is another area where problems of inadequately filled positions are aggravated by equipment shortages. According to a state survey, only a third of operating theatres are sufficiently equipped (Planning Commission 2001).

Adapted from Radermacher, *forthcoming*

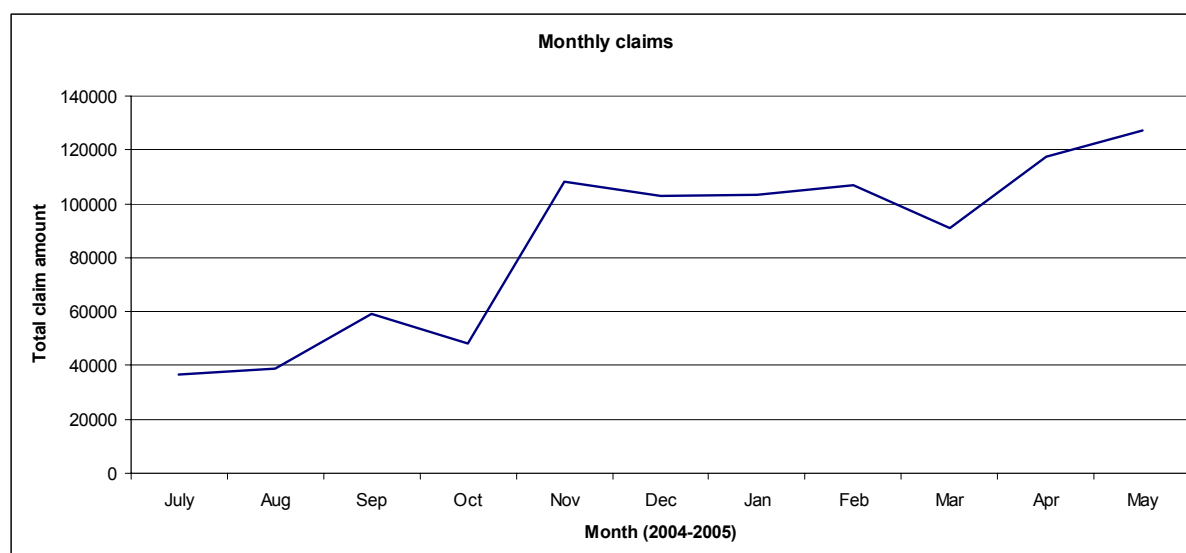
Public facilities offer free treatment for those living under the poverty line or charge very modest fees. This applies to surgery and hospitalisation, OPD and (partly) drugs. A basic package of drugs should be available at all public health facilities. The patient must purchase drugs not covered by this basic package, and sometimes drugs normally covered by the basic package are not available.

The basic idea of Karuna Trust is to use these free services instead of making the poor purchase them from other sources. The benefit package tries to compensate for the weaknesses in the public health care infrastructure through the following key features:

**Compensation of wage loss.** If the policyholder is hospitalized for more than 24 hours in a public health facility, Rs. 50 (\$1.10) is paid per day as compensation for wage loss, for a maximum of 30 days per year. All cases of hospitalisation are eligible.

The amount paid is above the average amount a daily wage labourer earns. Since the target population cannot find work throughout the year, some moral hazard can be expected. Analyzing Karuna Trust's claim data of 2004/05 (see Figure 4.2), it becomes obvious that the monthly amount claimed increases over the (insurance) year. This can be due to two effects: 1) increased understanding and therefore increased knowledge how to claim; or 2) compensating months without work or trying to “get the money invested back”. While the first reason would be very positive, a dominance of the second reason would indicate moral hazard (and potential collaboration of client and doctors in filing these claims).

**Figure 4.2 Monthly Claims (2004/05)**



Although the daily compensation of wage loss might be above the average income of a daily labourer it should be kept in mind that often – in case of real illness – an accompanying person also loses wages. And as there is no paid sick-leave for workers in the informal sector the benefit offered by Karuna Trust is very important. By compensating for wage loss, Karuna Trust hopes to lower the barriers for seeking appropriate care early on.

**Drug fund.** As spending for drugs to treat illnesses can become expensive, Karuna Trust has also included coverage for drugs. Basic drugs are provided by the public health facilities. In the case of hospitalization, if additional drugs are needed, they are also provided by the health insurance scheme. To cover the costs of these drugs, Karuna Trust established and administers a drug fund that allocates Rs. 50 (\$1.10) per hospitalised person per day. A maximum of 30 days, i.e. Rs. 1,500 (\$34), is covered per person. If the drugs needed for one patient are cheaper than the number of days hospitalized times Rs. 50 (\$1.10), the balance remains in the drug fund. Patients whose drugs are more expensive enjoy the benefits of this balance. It is the duty of the respective facilities to keep a stock of the necessary drugs.

Karuna Trust has partnered with a provider of quality generic drugs to save money. The health facilities submit a list of drugs needed and Karuna Trust supplies these drugs. These drugs are not supplied on the basis of each case but in bulk in advance. Currently, 46 different drugs are supplied. The hospitals record the use of the drugs but there are no additional checks from Karuna Trust's side so far. This certainly opens the door for fraud and misuse and effective monitoring needs to be introduced.

If patients use public facilities outside T. Narsipur taluk, Karuna Trust reimburses this patient up to the maximum coverage applying. Drugs for OPD or follow-up treatments beyond hospitalization are not covered.

**Additional benefits in case of surgery.** In the event of surgery, Rs. 500 (\$11) is paid to the patient as compensation of wage loss in addition to the benefits received for being hospitalized. This benefit is intended to be an incentive for the patient to take ten days off from work to recover after surgery. Additionally, Rs. 500 (\$11) is provided from the drug fund for drugs necessary during or after the surgery. Clients are only eligible for this benefit once a year.

**Ambulance.** Karuna Trust tries to respond to the geographical distance of some of its clients from the designated health facilities by offering emergency ambulance transport. The costs for ambulance are usually borne by the drug fund. Karuna Trust operates one ambulance at the T. Narsipur hospital, and the hospital operates a second ambulance.

The insurance benefits offered by Karuna Trust effectively reduce a big part of the risk faced by low-income households. However, important risks, like drugs and tests for OPD, remain uncovered. Further, only focussing on public providers might not respond to the clients' preferences – but it keeps the costs of the product low. Although this product is certainly good and attractive, Karuna Trust might wish to check the preferred benefit package in a participatory approach and balance the preferences expressed by the clients with their reported willingness to pay. In the 2005 household survey, half the respondents reported a willingness to pay at least Rs. 300 per household per year for health insurance.

### *Changes to Benefits*

There have only been minor changes in the benefits since the scheme's inception:

- **Increased coverage:** The number of days covered in case of hospitalization was increased from 25 to 30 days after the first year as a positive financial balance remained. Socially committed, NIC agreed to increase the number of days covered.
- **Mechanism to cover drugs changed:** In the initial phase of the insurance scheme, the patient purchased drugs and was later reimbursed. This resulted in high costs for branded drugs and so it was decided to supply generic drugs directly through the health facilities.

### *Special Needs of Women and Children*

About 56% of the insured covered by Karuna Trust are women. Many of these women are members of Karuna Trust's SHGs and therefore have close contact to the organisation anyway. They subscribe as individuals sometimes with and sometimes without other members of their family. As Karuna Trust's insurance product covers any admission to a public hospital, child delivery, caesarean and other needs of women are covered.

## 4.4 Premium Calculation

The premium was mainly established based on an estimate of the target group's willingness to pay for health insurance. In its preparative study, CPD estimated a household's willingness to pay to be Rs. 111 (\$2.50) per year for the proposed benefit package.

In negotiations with NIC, Dr. Sudarshan strongly advocated for the lowest possible premium. The actuaries in NIC's headquarters were concerned about a premium of Rs. 30 (\$0.70) per person per year as they expected it was insufficient to cover the claims, but NIC finally agreed to give it a try. In an MoU with Karuna Trust, a maximum claim ratio of 150% was fixed. As claims in the first year were not even at 100%, it was agreed to lower the premium to Rs. 22.5 (\$0.51) (and increase the number of days covered). In the third year of the scheme (2005) – the first without UNDP subsidies – an amount of Rs. 22 (\$0.50) was collected even before NIC officially revisited the premium structure. But since the claim ratio in the second year was around 115%, an agreement on a premium of Rs. 22 (\$0.50) was reached.

**Operating costs.** There has been no detailed analysis of the operating costs, but they are estimated to be around 20-30% of the premiums collected. Around five percent (Rs. 1 per policy) of the annual premium collected is given as a commission to Karuna Trust. The balance is cross-subsidised from the NGO's other activities.

**Subsidies and grants.** In the pilot phase, between 2002 and 2004, the scheme was heavily subsidised by UNDP. About \$450,000 was invested in the development of the pilot schemes in T. Narsipur and Bailhongal and the expansions in two other taluka. A significant proportion of the money was spent on subsidised premiums (see Table 4.2).

**Table 4.2 Subsidies and Grants**

	BPL SC/ST		BPL non-SC/ST	
	Subsidy	Insured Person	Subsidy	Insured Person
Year 1 (2002)	30	0	10	20
Year 2 (2004)	22.5	0	0	22.5
Year 3 (2005)	0	22	0	22

Only BPL families can join Karuna Trust's insurance scheme. Usually, the members of the SHGs determine who is considered as BPL in their community and who is not although the scheme officially requires potential clients to prove their BPL status with their ration card (see Box 4.2). Scheduled castes and scheduled tribes, which represent 72% of the population in T. Narsipur taluk, enjoyed a higher subsidy in the pilot phase of the scheme. This was introduced to respond to the political agenda of paying special attention to these groups.

#### Box 4.2 Ration Card<sup>16</sup>

The Target Public Distribution System, an instrument of the Indian Government to alleviate poverty, distributes essential commodities through fair price shops/ration shops to people below the poverty line. Families belonging to the vulnerable section of the society, like rickshaw-pullers, landless labourers, fruit and vegetable sellers, etc. are usually counted as BPL people. The fair price shops mainly offer rice, wheat, sugar and kerosene. It is in the responsibility of the state governments to allocate and distribute the commodities, identify people below the poverty line and issue ration cards, which are needed to buy the highly subsidised goods. Only ration card holders can purchase consumer goods from fair price shops.

State governments dispense quite different types of ration cards and for different purposes. Some provide ration cards for all residents as identification document; others define a certain income limit that cannot be exceeded by a ration card beneficiary. In some states, different ration cards are provided for people living in rural areas than for slum dwellers. The state government decides who is entitled to a ration card and what kind of restrictions are made for certain income groups. Some states charge a fee for the ration card of about Rs. 5. Additionally, they ask for passport pictures and application forms. Some states, like Karnataka, demand for very detailed personal data. In case poor applicants cannot provide the demanded documents, the state of Karnataka sends food inspectors to verify the reliability of the person. The ration card became an important tool of identification. When applying for documents like a Domicile Certificate or for the inclusion in the Electoral Rolls, the ration card can be used.

#### *Summary and Issues*

The insurance scheme currently exceeds a claims ratio of 100%. The losses are borne by NIC to fulfil its social commitment. The premium charged will be reviewed on an annual basis and can be adapted if the claim ratio exceeds 150% or comes close to it. The premiums are low only because of the goodwill of NIC. This goodwill can be expected to remain as long as NIC's management feels socially committed and the scheme does not extend its operations very much. If the scheme would be replicated in other locations (which would increase the risk borne substantially), it can be expected that NIC will revise its policy.

A further way to keep the premium low is to tackle potential fraud in the scheme before it increases to a threatening size. There are many loopholes that allow individuals to take advantage; and Karuna's monitoring has not yet developed to a strict system.

<sup>16</sup> Sources: <http://india.gov.in>; [http://fcamin.nic.in/ctzn\\_ind.htm](http://fcamin.nic.in/ctzn_ind.htm); [http://planningcommission.nic.in/reports/sereport/ser/std\\_pdstn.pdf](http://planningcommission.nic.in/reports/sereport/ser/std_pdstn.pdf)



## 4.5 Premium Collection

### *Collection Processes*

Premium collection is carried out side-by-side with enrolment. As Karuna Trust recognized that convincing clients takes time, it decided to switch from an annual campaign to a number of subscription batches through the year. In 2005, enrolment continued for six months and the clients were registered with NIC in four batches. NIC's district office was not entirely happy with this procedure, but finally accepted it. Karuna Trust now needs to indicate the number of the subscription batch number when transmitting claim documents. Karuna Trust considers switching back to annual subscription in 2006 with a subscription period in October-December when potential clients have most income. During premium collection in July 2005, it turned out that many daily labourers were unable to find employment and therefore advocated for changing the time of premium collection.

Karuna Trust mainly uses its social workers, but also relies on field offices to collect the premiums. The social workers at Gram Panchayat level attend most of the meetings of the self-help groups. The SHGs are the institutionalised contact point between Karuna Trust and many potential clients and therefore play an important role in the subscription and collection process. Some groups organise regular savings to pay for premiums and hand this amount over to Karuna's staff; others collect the full amount in one month.

Additionally, social workers visit households not participating in the SHGs. If these households or SHG members cannot pay, social workers visit them a second time. The programme coordinators also attend community meetings and visit households to collect premiums. Many clients directly address the social workers in the health facilities or visit Karuna's field office.

The premium collected is accumulated at the field office and deposited to a bank account every few days. When the enrolment period is over, the money is transferred to NIC along with the list of the members.

### *Problems (and Solutions)*

Since many people handle many small amounts (accumulating to bigger ones), fraud and misuse can be expected. Some of the social workers did not directly forward the money to Karuna Trust's office, but paid some of their own bills first. Karuna's administrative staff detected the problem by cross-checking the receipts issued (numbered consecutively) with the amount submitted. After strict intervention from the project coordinator, the open amount of approximately \$1,000 was repaid by the respective individuals.

Since the scheme was initially designed with fully subsidized premiums for most members, little attention was paid to the process of premium collection. After the end of the pilot phase, there were no longer any subsidies and all members had to pay the full premium amount. Premiums were collected in June and July. Although there are some harvesting activities then, there was little employment for most daily labourers as machines were used in this harvest. Many households faced severe difficulties in paying the premium since some had barely enough money for food. SHG members used their health loan fund to pay for the

premiums. Others borrowed money from moneylenders. All agreed that September to November would be a better time for premium collection since they expected to have sufficient work then. Karuna Trust extended the collection period to cater to these needs.

Fraud and misuse of premiums is a big problem for which no proper mechanism is in place yet. A number of incidences have been detected, but it is likely that some remained undetected. The advantage of a decentralized structure for information flow and distribution of the product turns into a disadvantage when strict control is needed. There is room for improvement in this.

## 4.6 Claims Management

Only public health providers — mainly secondary health care institutions with specialists such as community health centres or general hospitals — are eligible to participate in the insurance scheme. If possible, clients bring the receipt documenting their payment of the insurance premium. A list of insured clients, available from the social workers, is placed in these institutions. If they are not approached directly by the client, they check the admission book and contact the client. The client's receipt is compared with a copy of the receipt kept in Karuna Trust's T. Narsipur office. This mechanism ensures that clients cannot add names themselves (as they did in previous years); but without a photo ID it remains difficult to identify the claiming person if not personally known to the social worker.

At the time of discharge, a discharge summary is prepared by the treating doctor. Based on the number of days hospitalized, the social worker directly gives compensation for wage loss to the beneficiary or a lump sum payment in case of surgery (point (2) in Figure 4.3). Sometimes, the client is reimbursed on daily basis. This is recorded by the social worker on the back of the receipt slips (called "voucher"; see Annex 2). The social worker can directly reimburse a client from the emergency fund of Rs. 5,000 (\$114) that she/he carries.

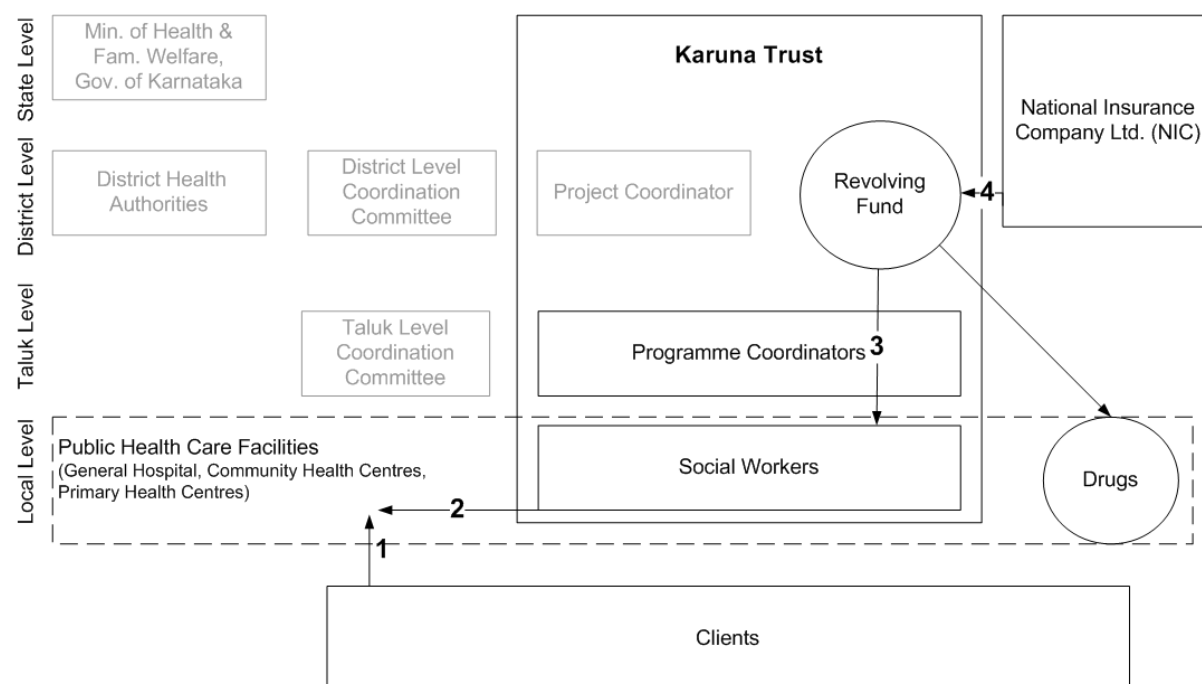
After the client is discharged from hospital, the social worker submits the discharge summary and the voucher to Karuna's field office. The programme coordinators and the manager check the documents and refill the social workers emergency fund from the revolving fund (3).

On a weekly basis, a programme coordinator visits NIC's divisional office and submits a summary of the claims to the insurance company. The original documents are kept at Karuna's office. Based on the summary submitted, NIC reimburses Karuna's revolving fund (4). NIC is not involved in the administration of the drug fund.

Claims are more likely to be settled with delays if the patient was admitted to a public hospital outside T. Narsipur taluk. Although all public hospitals are eligible in the scheme, claims are sometimes delayed due to missing documents. Only very few rejections have been reported; in these cases clients used private facilities and tried to claim benefits.



**Figure 4.3 Transfer of Funds**



**Table 4.3 Claims Settlement Details**

Issues	Observations
Parties involved in claims settlement	<ul style="list-style-type: none"> <li>• Doctor issuing discharge summary</li> <li>• Social Worker</li> <li>• Karuna Trust Field office</li> <li>• Insurance Company</li> </ul>
Documents are required for claims submission	Discharge summary
Claims payment method	Cash to the patient usually when discharged
Time from insured event to claim submission	0 days
Time to pass through any intermediaries	0 days
Time from submission to payment	Max. 1 day, usually immediately
Time from payment to client until reimbursement of revolving fund through insurance company	Approx. one week
Claims rejection rate	Very low

### 4.7 Risk Management and Controls

Karuna Trust and the insurance company are partnering with the mutual intention to help the poor. Because of this social mission, risk management is barely applied as losses are borne by the insurance company. The scheme is intended to give maximum benefit to the clients. Since there have been no financial problems yet, this policy is unlikely to change dramatically in the near future. However, some features require some risk management mechanisms and should be improved as soon as possible:

**Moral hazard.** Doctors who make decisions about admission have a perverse incentive as their hospital is eligible to receive drugs as required from the drug fund worth Rs. 50 times

the number of days the patient is hospitalized. Doctors submit a list of drugs used to Karuna Trust and get their stock refilled afterwards. As it is difficult for Karuna Trust to control the drugs used with regard to the single patient (information asymmetry), it is possible that doctors use the drugs for other patients.

**Adverse selection.** There is no direct mechanism to avoid adverse selection. However, Karuna Trust is keen on providing insurance coverage to a broad population and hopes to get a balanced mixture of good and bad risks through this. But since there is no waiting period, some clients might join when they already know that they will use the insurance; this behaviour is even encouraged by giving clients the possibility to join in the hospital. This risk is partly controlled by having limited enrolment periods.

**Fraud.** It is difficult to estimate the extent of fraud in the scheme but there are a number of loopholes where fraud is likely to occur. Where people handle money, fraud is likely to be not far behind. To receive benefits, patients need to submit the discharge summary signed by a doctor. Since doctors are aware that their signature is worth Rs. 50 (\$1.10) per day of hospitalisation, there might be a few cases where some of them charge a “processing fee”. The extent of this problem is difficult to estimate. The project coordinator is aware of this weakness and has instructed field staff to randomly interview clients about the amount received and fees paid. Currently, Karuna Trust has a strong position with the public health providers as Dr. Sudarshan, the Hon. Secretary of the Trust, is Vigilance Director of Karnataka and chairs the department that fights corruption.

There is also the danger that the doctor and the beneficiary collaborate when the doctor makes the patient stay in hospital longer than needed (or maybe it is even not needed at all) since both could share the cash paid by the insurance.

Fraud can also occur within the organisation since many people are involved in handling money, like the social workers when collecting premiums and paying claims. Karuna Trust’s management strictly monitors and immediately acts when such a case occurs, but some cases may remain undetected.

**Cost escalation.** By defining a cap for benefits (max. 30 days plus surgery), cost escalation is reasonably controlled. Additionally, Karuna Trust undertakes some illness prevention by running a number of herbal gardens in six villages. Villagers get trained to produce herbal medicine; currently, about 40 different syrups and powders are produced.

**Covariant risk.** As the insurance serves a small geographic region, the scheme is vulnerable to covariant risk.

## 4.8 Marketing

Karuna Trust recognised the importance of a strong marketing mechanism as CPD’s feasibility study revealed that the target group lacked awareness about insurance. Since the insurance product was fully subsidised during the pilot, information about being insured and how to utilise the benefits of the insurance was all the more important as clients might tend to take what is for free without knowing about it (which would undermine the idea of making insurance attractive by subsidising the first years). Karuna Trust, together with its partners

and a budget of Rs. 120,000 (\$2,727) for the first year, initiated the “Information, Education and Counselling” (IEC) component. This was a broad marketing and information campaign.

Information was provided about the concept of insurance, the benefits covered, and the premium structure (total premium and amounts subsidised for different groups). A broad variety of information tools were used. The most important tool was Karuna’s infrastructure itself, i.e., the social workers at the Panchayat level and those at health facilities. Even today, they are the main source of information between the insurance scheme and the clients. Briefing notes for the staff have been developed (Annex 5). Additionally, a multipurpose education vehicle equipped with video facilities disseminates information. This van, funded as part of Karuna’s other activities, visits villages in Karuna’s project area regularly and it is a heartily welcomed visitor. Information was also provided through newspapers, TV and in cinema advertisements.

The insurance scheme also made use of the public structures in place. Karuna briefed Gram Panchayat officials and asked them to distribute information as part of their contribution to local development. In addition, the staff at the hospitals informed patients about the scheme and referred them to Karuna Trust’s contact persons.

When the first clients enrolled, they received printed pamphlets with detailed information on insurance. These were distributed on a relatively large scale. Additionally, billboards in various locations were also used. These marketing mechanisms have not been used during the recent enrolment periods when all clients had to pay the full premium amount for the first time. Although marketing tools were needed the most, the lack of funds restricted information dissemination to verbal communications from Karuna’s staff.

In its Endline Evaluation Report, CPD evaluated the effectiveness of the information channels used. The main sources of information on benefits were billboards. The Karuna Trust personnel and pamphlets have also been significant source of information for the households in T. Narsipur taluk. The Karuna Trust personnel supported the distribution of the pamphlets. Other health personnel, TV and newspapers have also been recognised as important sources of information. Although a good number of the households were well informed about benefits, many households still did not purchase insurance. The main reasons given for this was still lack of information, lack of time to enrol, being away from the village and not knowing whom to approach.

Households felt that additional sources of information could be useful. To improve knowledge about benefits, households wish to have additional information through public announcements, Gram Sabha meetings<sup>17</sup> and discussions as well as street plays.

The marketing role of SHGs is significant. In T. Narsipur taluk, about half of the policyholders were members of a self-help group.

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<sup>17</sup> The local authority (Gram Panchayat) needs to organize a Gram Sabha meeting every six months. All villagers are invited to attend to hear about ongoing activities and public social schemes. The villagers are requested to define the beneficiaries of the social schemes in these meetings i.

## 4.9 Customer Satisfaction

Client satisfaction seems to be quite high, although it is being reassessed with the “new” price charged for the product. Clients indicated their satisfaction, especially with regard to the compensation of income when hospitalised. This was perceived as being very useful.

The CPD Endline Evaluation Report corroborates this perception. In T. Narsipur more than 95% thought the scheme as useful (which was still free at this time). Even more than 90% of those who are not insured had a positive perception of the scheme. Compensation for wage loss and providing costs of medicines were perceived as best features.

A number of (potential) clients want private health providers to be included, as they are perceived as providing better quality and are often closer to home. For some villages, public providers are quite distant. Many (potential) clients from these villages are not willing to travel the distance to the designated facilities. According to CPD’s survey, almost 15% do not want to use the designated facilities because doctors demand money.

At the end of the subsidized scheme, two reactions were observed. Approximately 70% did not agree to start paying for services that were free in the year(s) before; but the number is declining with ongoing discussion and information provision. They feel cheated or regard the price as too high. Another group is willing to pay for insurance and has assumed ownership. They feel that they get value for their money, but many ask for OPD coverage and hospitalization at private providers.

## 5. The Results

### 5.1 Management Information Systems

The information system is not very sophisticated, but it allows for the comparison of the ratio of premiums collected and benefits paid. The causes of illness are noted down in a register and on the discharge summary. Additionally, through its network of social workers, Karuna Trust can benefit from qualitative information. This information is shared monthly during staff meetings. The project coordinator chairs these meetings and can partly track performance through this.

### 5.2 Operational Results

The insurance scheme underwent a massive change when it asked clients to pay premiums. In the subsidised pilot, Karuna Trust insured all persons in direct contact with the organisation. Flanked by massive information and education, the clients were supposed to experience the benefits of insurance and learn about its underlying principles. This was intended to make marketing the insurance product easier when subsidies ended.

This strategy might be judged as a partial success since approximately half of the clients renewed their policy even though they had to pay for it. Many feel that they will get value for their money. But Karuna Trust now acknowledges that it might have been easier having started with only partial subsidy and put more emphasis on continued education and information. CPD's evaluation (before paying) shows that understanding of insurance has increased tremendously among the target population. Nevertheless, some clients who were insured for free were not aware of the coverage and hence did not use it.

Linking the scheme with the public infrastructure can be regarded as a successful experiment as it enabled the scheme to use what is offered for the target group by the government and to complement it with additional benefits, which makes it more attractive. It is also beneficial for the designated health facilities as their services experience higher utilization and their possible bad reputations might be reassessed. Unfortunately, it cannot be assessed whether the quality of services did improve through this scheme as at the same time a Government and World Bank project invested heavily in Karnataka's health care infrastructure.

### 5.3 Financial Results

With the current premium, the scheme depends on subsidies, which were from an external donor during the pilot phase and from the insurance company since then.

**Table 5.1 Key Results**

	2005	2004	2003	2002
Net income (net of donor contributions)	583,660	Scheme donor funded		
Total premiums (value in Rs.)	583,660	1,334,873*	1,011,480 <sup>a</sup> 1,631,400 <sup>b</sup>	2,552,760*
Growth in premium value	-56,78%	-47.71 % <sup>c</sup>		
Claims / total premiums (%)		115.33	40,99 <sup>a</sup> 14,11 <sup>b</sup>	23.33
Administrative costs / premiums (%)	41%**	18%**		
Commissions / Premiums (%)	5 %	5 %		5 %
Claims cost per total number insured (Rs.)	193,000	939,387		
Growth in number of insured (%)	-56,67	-28,04		
Renewal rate (%)	No record kept			

\* Subsidised by UNDP

\*\* Estimated administrative costs of Karuna Trust (without NIC) cross-subsidised mainly through other activities of Karuna Trust

<sup>a</sup> Chamarajanagar taluk (operation only from 31<sup>st</sup> March 2003 until 29<sup>th</sup> Feb. 2004), premiums subsidised at 100% as only BPL SC/ST people were covered; In T. Narsipur the insurance was reintroduced on 1<sup>st</sup> June 2004. Chamarajanagar taluk is now operated from T. Narsipur as part of this taluk's scheme.

<sup>a</sup> Belgaum taluk (operation only from 16<sup>th</sup> June 2003 until 31<sup>st</sup> March 2004), premiums subsidised at 100% as only BPL SC/ST people were covered.

<sup>c</sup> Comparison is taken with respect to 2002 as renewal in T. Narsipur was delayed from 2003 to 2004.

## 5.4 Impact on Social Protection Policy

The pilot project was explicitly designed to field test possible options for insuring the poor. A second experiment with the same benefit package was launched at the same time in another taluk in Karnataka (Baillhongal). It used the public health infrastructure to provide and distribute insurance; no NGO was involved. Both field experiments were meant to be replicated. The Karuna experience is intended to demonstrate how an established NGO can provide health insurance while making use of the public infrastructure.

Some people in the ministries prefer the approach without NGO involvement. This is not a surprising view considering their affiliation. However, a further more substantial point is that many successful NGOs, including the Karuna Trust, are strongly linked to one charismatic person leading them during their rapid development. These organisations can collapse just as fast as they evolved if the focal person is either no longer with the NGO or his reputation is damaged. Insurance needs a stable structure in long-term operations; this is why some prefer to build on existing public structures, which might be less personalised than some NGOs.

## 6. Product Development

On behalf of Karuna Trust and financed by UNDP, the Centre for Population Dynamics conducted a baseline study. This study intended to give a detailed picture of the socioeconomic situation among the target group, their health seeking behaviour, as well as their knowledge about insurance. Information on spending for health was included as well as availability of the health services.

Although treatment in public facilities is free in theory, the study revealed that many households have to pay for drugs and some other services. This led to the inclusion of drugs into the benefit package. Including compensation of wage loss into the benefit package is hoped to overcome the observed economic problems faced by households in case of illness. Based on this research, the price and the specific benefits were determined. These were then proposed to NIC, which was extremely sceptical about the viability of the scheme. To take account of their concerns, a maximum loss ratio of 150% was defined and the collaboration between NIC and Karuna Trust was fixed in a MoU.

From 2002-2004/05, the insurance product was tested. It was introduced as a subsidized scheme and every person in direct contact with one of Karuna's other activities was insured (i.e., not mandatory but for free anyway). The experience was monitored and evaluated. After two years, insurance subsidies were removed and since 2005 clients have to pay for insurance.

The Endline Evaluation Report revealed an increased understanding about insurance. Policyholders, including those who had not claimed benefits, were aware of the benefits and how to claim them. Making the clients pay for insurance was the challenge in 2005.

During the pilot testing, two changes in the benefit package were introduced: 1) the number of days covered in case of hospitalisation was increased from 25 to 30 days for the compensation of wage loss and for the drug fund; and 2) the mechanism for providing drug benefits was changed. In the initial phase, drugs were purchased by the patient from outside the designated facility. In order to not put a financial burden on the client through paying the drugs upfront, the client received the money in advance and provided the bill after purchasing the drugs. If the person spent less than eligible for the money was paid back to the drug fund for later use of other patients; if the patient spent more, it was on her expense. This resulted in high costs for branded drugs and so it was decided to supply generic drugs directly to the designated health facilities.

The total costs of developing the product, implementing it and subsidising the premiums in the first two years (2002 & 2004) in T. Narsipur and other taluka is estimated to amount to \$450,000. CPD's baseline study cost around Rs. 200,000 (\$4,545). UNDP provided the funding for the development and the initial test phase.



## 7. Conclusions

### 7.1 Significant Plans

Karuna Trust looks back to a successful health insurance pilot although it would not replicate it in the same way anymore (only with partly subsidised premiums). Nevertheless there is pressure, especially from the clients, to modify the product. The maximum coverage is planned to be increased and ways to include private providers in the provision of the benefits are being considered.

Karuna Trust, together with UNDP and NIC, plans to introduce a pilot insurance for antiretroviral drugs for people who are HIV positive. Following a study conducted on behalf of UNDP, Karuna Trust's insurance scheme is going to be one of the three field experiments for insuring HIV/AIDS. This benefit will be added to the package for all insured clients.

### 7.2 Key Issues Summary

Karuna Trust, together with its partners NIC, the Government of Karnataka and in the pilot phase CPD and UNDP, managed to integrate a health insurance scheme in the existing structures of public health care provision. The scheme complements this structure and therefore offers improved risk management for the target population. Initiating health insurance was a logical step for a NGO like Karuna Trust, which had worked on health issues for a long time. The trusting relationship Karuna has with its clients makes it a perfect distribution channel.

When designing the scheme, the consortium did well in including a research organization like CPD in the conceptualisation. It enabled Karuna Trust to offer a product highly desired by its clientele. A solid baseline study prevents microinsurance schemes from modifying their product too often and hence confusing clients. The money for the study was well invested, although it has to be acknowledged that this money would not have been available without external support.

But external support can also create some problems. A fully subsidised premium – like in this case – might help to distribute the product easily and might be tempting for a NGO trying to generate as many benefits as possible for its clientele. But in retrospect, it might not have been the best idea. It is difficult to convince clients to pay for insurance that was given free the years before. Karuna Trust now strives to overcome this problem, but lacks a marketing budget. Investing in marketing and education and a partial subsidy might have been a better idea.

Nevertheless, the benefits offered are compelling. Compensation of wage loss when hospitalized is a benefit usually not available in the informal sector. It can lower the barrier to seek care early on and help to improve the health status of the clients – not to mention prevent some of the economic hardship illness can cause. Also, the burden drugs can cause is well recognised today. Responding to the unavailability of certain drugs in the public

facilities by supplying them for the insured is a needed benefit. Only public providers are not every client's first choice. But using the services they provide for free to poor patients helps Karuna Trust keep the premium at an incredibly low level – but only as long as NIC accepts some losses as part of its social commitment.

Unfortunately, fraud seems to be a problem in the scheme. This is a logical consequence of dispersing money in cash. But there are many loopholes in the scheme. Developing stronger and more institutionalised control mechanisms is Karuna Trust's next big task.

# Annex 1: Inpatient Register

Sl. No.	I.D. No.	I	D	C	No	Name AND Address	cast	age	occu	Health prob	From	To	Total Days	Patient med.	SURGERY	Total	PV	DI	Pay	20	
69	21 (68122)	1	10	1	35	Rajamma w/o Shivanna Kothegala T. Narasipura	SC	24	cast	Tuberculosis	26-7-04	1-8-04	7 days	350	350	500	500	700	69	4/17/04	28-8-04
70	10614	1	16	4	7	Sadani/Shamika D/o Swamy Hunasur T. Narasipura	SC	10	cast	Vermicella	14.06.04	20.06.04	7 days	350	350	-	-	700	70	K.R.H Mys	6/8/04
71	1199	1	26	5	11	B. P. mahadevappa s/o Puttamadappa Benakara Halli T. Narasipura	Man SC/ST	45	cast	Allama	29-7-04	31-7-04	3 days	150	150	-	-	300	71	K.R.H Mys	6/8/04
72	31 (66100)	1	18	1	59	mahadevanma w/o mallesh Madapute T. Narasipura	SC/ST	23	cast	Tuberculosis	26-7-04	1-8-04	7 days	350	350	500	500	700	72	K.R.H Mys	6/9/04
73	66116	1	20	1	111	Siddasaige s/o madavah NKKalagose T. Narasipura	SC/ST	35	cast	dog bite	26.6.04	29.7.04	30 days	1500	1500	-	-	3,000	73	K.R.H Mys	6/9/04
74	896	1	25	4	46	Sudha w/o Ravi Siddara Hundi T. Narasipura	SC/ST	24	cast	Head wack	4.6.04	15.6.04	12 days	600	600	-	-	1,200	74	K.R.H Mys	7/5/04
75	1202	1	27	4	44	Charna Keshava s/o mahadeva Hunagana Halli T. Narasipura	SC/ST	12	cast	fever	30-7-04	5-8-04	6 days	300	300	-	-	6,00	75	Veerkatol	7/8/04
76	1214	1	16	3	46	Dundamma w/o mahadeviah Danayakarapute T. Narasipura	SC/ST	60	cast	ASLHams	2-8-04	6-8-04	5 days	250	250	-	-	500	76	Veerkatol	7.8.04

SC/ST Male = 2 Female = 5  
Nurse/ST Male = 1 Female = 0

## Annex 2: Voucher

**Project Head** **KARUNA TRUST**  
 Old Tirumakudalu, T.Narasipura- 571 124 • Payment  
 Ph : 95- 8227- 261565 • Advance  
**VOUCHER** Date :  
 Paid to.....  
 Rupees (in words).....  
 towards.....  
 Rs.  Receiver's Signature   
 Passed by \_\_\_\_\_ Accountant \_\_\_\_\_

Front side of voucher containing the summary

SL No	Name and Address	IP No	C No	IP No	Hospatation paid	D/m/yr
					Form TO Total days	
Total Amounts						

Backside of voucher, where social workers can note down single payments.







## Annex 5: Briefing Notes for Staff

