A QUALITATIVE ANALYSIS OF DECLINING MEMBERSHIP IN MICRO HEALTH INSURANCE IN KARNATAKA

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ABSTRACT
Micro health insurance (MHI) aims to tackle the impoverishing effects of huge medical bills. An understanding of the factors that act as barriers to enrolment is essential to enhance the risk pool and long term sustainability. This study was undertaken to ascertain the reasons for declining membership in a MHI scheme in Karnataka. A variety of reasons for declining membership such as lack of money, intra household factors, and lack of clarity on the scheme features was highlighted as barriers. Identification of barriers and designing the scheme according to the requirements of target population is the need of the hour.

Key words: Health care financing, health insurance, barriers, financial protection, micro health insurance
Introduction

Developing countries including India, struggle to provide quality health care to the population due to insufficient resources and lack of commitment by the governments. It is disheartening to note that India has 16 % of world’s population but spends a meager 3.6 % of GDP while the private sector spends a major chunk (75%) of total health expenditure (WHO, 2009). Of total private health expenditure, 91.4 % is out of pocket (OOP) that has pushed 24 % of people who were hospitalized below the poverty line and has forced 40% of them to resort to risk coping strategies with negative consequences such as borrowing and sale of assets (Peters et al., 2002).

Micro health insurance is a pivotal mechanism aimed at poorer households to improve their access to health care system at a lower cost. SampoornaSurakshaProgramme (SSP), a micro health insurance (MHI) scheme offered by award winning micro finance organization, is one such initiative in Karnataka, India. In 2013-14, SSP enrolled 13 lakh members and premium amount mobilized was ₹44.18 crore. A total of ₹36.44 crore were disbursed as claim benefits in the same year. Except 2013-14, SSP has incurred loss since inception due to insufficient premium collection and high level of claims. The number of enrolled members increased by 42.7 % in the second year of operation (2005-06), 90 % in the third year (2006-07), but the growth was slower in the later years till 2010-11. It was negative in 2011-12 (-0.11 %). More so, the coverage of target population suggests declining membership. It was 53.4 % in 2004 that reduced to 47.7 % in 2005, 38.7 % in 2008 and 32 % in 2011. Another observation is the higher level of claims ratio (208%) in 2004-05, that reduced significantly (113%) in 2007-08. However, it deteriorated to an alarming level of 197.5 % in 2009-10. On an average, the claims ratio is 107.5 % in the last six years. The deficit in premium collection is absorbed by insurance companies that provide medical risk coverage. Thus, financial sustainability of any MHI depends on enrolment and the claims disbursed. In this background, declining membership in SSP is disturbing since only 32 % of target population (self-help groups) has enrolled in 2011-12 and the remaining has
not joined. Hence, this study was conducted to understand the factors underlying non-enrolment and non-renewal in SSP.

Existing literature on non-enrolment in MHI classifies the factors as demand side and supply side factors. Demand side factors include income of the family (Jutting, 2001; Jakab and Krishnan, 2001; Msuya et al., 2004), high level of premium (Atim, 1998), quality of care offered at the health centre (Criel&Waelkens, 2003; Basaza et al, 2008), and area of residence, seasonality of income, family size and quality of health care facility (Jutting, 2003). From the supply side perspective, technical design factors such as unit of enrolment (family or individual) (Schneider &Diop, 2001), timing of collections of premium (annual or monthly) (Bennett et al., 1998), awareness about the scheme (Basaza et al, 2008) and trust in the integrity and competence of management of the scheme (Basaza et al, 2008) also influence enrolment in a scheme. Renewal decisions depend on the education of the household head, submission of claim in the previous year, socio-economic status, and trust in the scheme and participation in the management of the scheme (Sinha et al, 2007). To the knowledge of the authors, there are few studies reported in the available literature on non-enrolment in MHI from India. This study adds to existing literature on barriers to enrolment in MHI and aims to ascertain the reasons for declining membership in SSP. Based on the findings; certain initiatives that can improve enrolment and renewal in MHI in Karnataka state is proposed.

**Micro health insurance scenario in India**

Student’s Health Home was the earlier scheme started in 1952 in India. Since then, a number of schemes have been initiated in different parts of the country such as BAIF, DHAN, RAHA, SEWA, ACCORD, Karuna trust, Yeshaswini trust, VHS, and Navsarjan. Most of them sprung from parent organizations that were either micro finance institutions (SEWA, ACCORD, Navsarjan) or cooperative societies (Yeshaswini). In the Indian microfinance sector, the partner-agent model appears to be the dominant institutional arrangement for the delivery of micro-health insurance although there are other two types; type I (HMO design) and type II (insurer design) (Devadasan et al., 2004). Most of the schemes are based on individual enrolment focussed on poor and mostly cover inpatient services. Some schemes provided coverage for other risks such as life, assets and natural calamities but majority of them restricted to health risk. Cashless treatment was offered by most of the schemes and network hospitals were mainly from
private sector. Subscription rate varies from 10 to 50% of target population (Devadasan et al., 2004). Most of these schemes were financially sustainable and have a life of more than a decade.

**SampoornaSuraksha Programme**

SampoornaSuraksha Programme (SSP) was started in 2004 by SKDRDP (Sri KshetraDharmasthala Rural Development Project) to provide financial risk coverage to its self help group (SHG) members in case of unforeseen consequences of ill health that results in hospitalization including maternity, death and natural disasters. At present, the programme is implemented in Dakshina Kannada, Uttara Kannada, Udupi, Kodagu, Chikmagaluru, Shimoga, Dharwad, Gadag, Haveri, Tumkur and Belgaum districts covering 8000 villages, 41 towns and numerous panchayaths. Total self-help groups (SHG) in 2011-12 were 1313042 households and SSP members were 420302 households. Disorders requiring hospitalization other than common ailments such as fever Since inception, Rs.1263463266 was given as cashless benefits to 393652 members and the premium collected was Rs.1174510053. In the year 2011-12, Rs.455493625 was paid in claims to 133962 beneficiaries. Net operating profit for the programme has been negative since inception. Net operating loss was Rs.222861658 in 2004-05, Rs.100711139 in 2005-06, Rs.204946664 in 2006-07, Rs.338198088 in 2007-08, Rs.356037862 in 2008-09, Rs.186869494 in 2009-10 and Rs.2192244819 in 2010-11.

**Research methodology**

The cross sectional exploratory study was designed to collect the qualitative data through focus group discussions and interviews with non-renewed and noninsured members and field staff in three districts in Karnataka state, India. Focus group discussions (FGD) were used to explore the perceived factors that prevented SHG members from becoming insured. This method allowed capturing opinions and perspectives of SHG members and nuances of opinions regarding non-enrolment and non-renewal in the programme.

**Sampling design**

The programme is offered in nine districts as mentioned above. From these, three districts namely DakshinaKananda, Utatra Kannada and Gadag were randomly selected based on human development index. FGDs were conducted in selected taluks in these districts namely Mangalore, Puttur, Sullia, Karwar, Kumta, Sirsi, Honnavar, Bhatkal, Gadag, and Shirhatti. Stratified purposive sampling method was used to select taluks for FGD. From each taluk, one circle (called as valayas) was selected. Participants were randomly selected using the list of SHGs available at the
taluk project office. In each circle, one FGD for households that didn’t renew their membership in the last year (10 FGDs) and one FGD for non-insured households were conducted (20 FGDs). Hence, data from 20 FGDs form the basis for the analysis on factors inhibiting enrolment in micro health insurance scheme. Each FGD consisted of 8 to 9 members and each discussion lasted for 45 minutes. FGDs were conducted in Kannada language and were video recorded with the consent of participants and was translated into English. Six interviews with administrators/office staff and field staff were conducted and were written down. Sampling strategy related to interviews with scheme administrators/staff was purposeful.

**Results**

The results of this study revealed several factors that resulted in non-enrolment and non-renewal in SSP. These may be broadly classified into extrinsic or demand side factors that include individual and household characteristics and intrinsic or supply side factors namely scheme characteristics that inhibit enrolment in SSP. Extrinsic factors were low income of family, unrealized benefits; multiple enrolments in health insurance schemes, lack of family support, withdrawal from self-help groups, lack of time to do to fill forms, all family members are healthy, not aware of the SSP and cultural beliefs. Intrinsic factors were complex claim procedure, inadequate benefit package, inflexible timing of collection of the premium, lack of good health care facilities.

**Extrinsic factors**

1. Low income of the family

The target population of SKDRDP is poor households with low income. Not only the income was low but also they had repayment of other loans;

   “...we have too much loan to repay... We don’t have money to pay premium..”;
   “...we don’t have much income..... I am planning to leave SHG as we have too many loans..”;
   “.prices have gone up... we have outstanding loans and payment of weekly installment of the loan itself is difficult..”

Low income of the family and increase in premium amount in 2011 may have resulted in unaffordability of premium;

   “..they (insurers) have increased the premium this year... It is difficult to pay..”

Provision of credit facility or lowering the premium to make it affordable by the poor is the remedied to improve enrolment. A credit facility has been provided by SSP to pay the
premium for those who can’t otherwise afford it. However, FGD revealed lack of awareness among participants about this facility;

“…it’s difficult to borrow to pay the premium.”, when asked were you aware of borrowing facility to pay the premium; “…no one has told us…If we knew, we would have enrolled in Suraksha.”.

2. Unrealized benefits
In regard to benefits of insurance, participants expected to claim from SSP at least once;

“…we have been doing Suraksha for many years..we didn’t get any benefits so far… We don’t want to continue”, “No one fell sick in the last two years…why waste money by paying the premium?..”, “…we didn’t get any benefit in these five years..we don’t want to continue..”, when asked “…didn’t that mean having illness? …Do you want to fall sick to claim?..”, reply was, “..we don’t want illness..but we don’t want to spend money for something which doesn’t benefit us…”, when asked again, “…you may benefit in future if someone fall sick in your family..”, reply was, “..we believe in Lord Manjunatha (of Dharmasthala, a well-known temple in DK district)...He will keep us healthy.”

3. Multiple memberships in other health insurance schemes
Multiple memberships in health insurance schemes either promoted by the government (Employees’ State Insurance in India) or sponsored by the employing organizations were expressed as another factor responsible for non enrolment.

“…we have ESI..we don’t want Suraksha…”, “....we bought Suraksha card although we had Yashaswini...We didn’t get benefit from both... No one was ill in the family..”.

Many have discontinued from SSP membership and had retained the other membership card due to higher amount of benefits and low premium.

4. Lack of family support
The most important social factor highlighted by the participants as an important factor for not joining or not renewing their membership was the lack of support from family, mainly objection by husband;
“…my husband was ill last year..he didn’t get benefit… He told me not to do this time..”
“..I don’t have approval from home..”The other reason was; “..my husband told me not to do..we need money...we can use premium amount for some other need..”

5. Cultural beliefs
People’s perception about health insurance has been influenced by local culture that stress ayurvedic system of treatment, home medicine (using herbs, shrubs and spices available at home to treat illness), and ‘karma’ philosophy (fate will decide everything including illness one gets).
Many participants stated;
“…Lord Manjunatah will keep us healthy…”, “…we trust ayurveda medicines..it doesn’t have side effects…”, “..if we buy insurance, we will get illness.”

6. New members
One of the main reasons was joining SHG membership after SSP enrolment period was over;
“..we joined the group (SHG) in May, we couldn’t join Suraksha..”, “…we have to join in February, we were not in group then..”

7. Other reasons
Inability to make time to attend meetings or pay the premium was highlighted; “..I was away from home when the enrolment took place in my village…”.
Formation of new SHG after the enrolment time was pointed out; and inability to continue SHG membership was another reason;
“..my family doesn’t allow me to continue in group (SHG), they have told me to pay back loan as quickly and leave the group..”
Domestic responsibilities including earning income kept many participants busy;
“..we have to cook, wash clothes and take care of elderly, so we take medicines from pharmacist or drink ‘kashaya’ (home medicine) if we fall sick”, “even if we have Suraksha, we have to forgo the days’ work but we can’t do that as we are poor”.
Since the household was the unit of enrolment specified by SSP, large families complained of inability to pay premium;
“..we have 6 people in the family but father only earns... we can’t pay premium for the entire family..”; “..I want to enroll my parents..others are healthy, then why enroll all?..”

Intrinsic factors
1. Inadequate benefit package
The participants stressed the need to include outpatient treatment in benefit package;

“..we get illness like fever, cough, we can’t get benefit as outpatient is not covered.”
“…we always go to a private clinic…it doesn’t come under network…”.

Even for chronic illness that requires admission, benefit amount was felt to be very low;

“…amount of benefit is too less, what will you get with Rs.5000?…they (insurers) should increase benefit amount and include common ailments…”

Exclusion of many diseases from coverage was another concern; “…Suraksha doesn’t cover many diseases which are common here…why insure when we can’t get the benefit?..”

2. Complex claim procedure

The lack of knowledge about rules for submitting the pre authorization forms and procedure to claim benefits was a problem as highlighted by field staff;

“…many eligible claims were rejected as insured members didn’t submit Suraksha card within 24 hours after admission…”,”people don’t bother about the name they give in the card and in the hospital…we have suggested them to give alias names and correct age

Also, admissions in non-network hospitals due to the lack of information on network hospitals resulted in the rejection of the claim. As per the contract between SSP and network hospitals, if medical bill exceeds the agreed package amount, the hospital has to bear the excess cost. However, it was passed to patients that resulted in non renewal;

“…when my husband was sick, we should have got Rs.20000 from Suraksha…but we got only Rs.5000… we had to pay the remaining amount..”

3. Lack of good health care facilities

Quality of care at care facilities was perceived to be low such as cleanliness, absence of medicines, and delay in payment to hospitals;

“….bed for men and women are kept together…. There is no privacy..the ward is not clean…”, “.doctors don’t discharge even if we are better as money is not sent to them by Suraksha office”, “.drugs are not available …”. The distance factor was expressed to be another concern; “.goodSuraksha hospitals are in Kumta (a city in UK district) which is far away…”, “.doctors don’t see us well, we have to go Hubli or Manipal for good hospitals (far away city).”.

4. Timing of collection of premium
Availability of money or time during the enrolment period (February of every year) stands out as a key factor affecting enrolment in SSP. There were opposing views among participants on the time of enrolment, it was suggested that;

“…Suraksha should be kept open throughout the year”,“…no, it should be done in February, we will keep postponing if it can be done any time in the year.”, “..we don’t have money in March season…if it was monsoon, we get more money working in fields.”.

Discussion
Health insurance as a health financing mechanism aims at higher revenue collection, larger risk pooling and strategic purchasing of health services (Carrin 2005) which in turn depends on membership in the scheme. Revenue collection strongly depends on enrolment that is influenced by affordability of premium, unit of membership, distance to network hospitals, timing of collection, quality of care and trust in insurance. In the current study, these factors were highlighted for non-membership except trust in insurance.

Inability to pay the premium due to low income was the single most important factor influencing non enrolment and non-renewal in SSP. The target population of the SSP is the poor, who work mainly in the informal sector. Spiraling inflation and stagnant daily wages have tightened the purse of these households. The premium has increased by 59 % for one member family, 37.3% for three member family and 28.4% for seven member family. Small family has to pay more than large family in terms of premium burden compared to last year. This was expressed to be too high given the low benefit amount (Rs.5000 per individual). Besides, the scheme has incurred loss since inception due to higher claims compared to revenue collected in the form of premium.

The suggested solution to the problem is subsidization of premium for the poor or providing credit facility with nominal interest rate to pay the premium. Interestingly, there is a mechanism to include the poorest in the programme in which a loan could be obtained to pay premium at once and repay the loan along with meager interest weekly. However, lack of awareness of the borrowing mechanism has deprived many households from being insured. Another alternative is to obtain subsidy from the government to partially offset the loss or to subsidize by engaging
corporate sector who would pay premium for the poor in the context of corporate social responsibility.

SSP insists household enrolment as a unit of enrolment to encourage participation of entire household that cross subsidizes the risk pool. Participants felt it to be undesirable due to higher premium burden, especially for large families. They failed to recognize that average contribution per household member was less than for smaller families. If SSP allows individual enrolment, there is a danger of adverse selection in which a family member with illness would join the scheme. This would choke the financial sustainability of the scheme.

Timing of collection of premium matters for health insurance scheme aimed at the poor in informal sector like MHI. Participants were inclined towards flexible enrolment that is open throughout the year like private for-profit insurance. Many households may not have surplus income to pay single annual premium due to seasonality of their occupation like agriculture. Some had domestic responsibilities that prevented them from filling forms, or attending meetings. However, flexible timing of enrolment would burden the field staff and leads to adverse selection. Filling forms and collecting premium would take lot of time of field staff who has higher responsibilities of micro finance programme. Instead of making the premium payment flexible, loan provision was made in SSP which was not utilized by non-enrolled due to unawareness or burden of too many existing loans. Moreover, people would join immediately after the illness if enrolment is made flexible which would promote adverse selection.

Low quality of care at the hospitals in the community, long distance to network hospitals and moral hazard behavior in some hospitals were the deciding factors for not enrolling in SSP. The management of the programme should be more sensitive to the concerns raised by members and take appropriate actions. It should stipulate stringent conditions of quality and terminate the contract with erring hospitals. Moreover, participants believed in ayurvedic medicine, nearby clinics or family doctors and home medicine that didn’t require insurance coverage. Domestic responsibilities inhibited some participants from getting treatment in hospitals when sick, de-motivating them to join insurance. This stresses the need for health education and awareness programmes on the benefits of MHI schemes.

The current study identified lack of awareness of insurance principles among SHG participants. Households without the incidence of illness in the last year and those who could afford treatment opted to stay out that shrunk the risk pool. In this regard, educating and sensitizing all family
members especially men regarding the benefits of SSP is highly needed. A successful health insurance scheme should have both healthy and sick such that cross subsidization and transfer of risk from sick to healthy, and from rich to poor. To cross subsidize, misconceptions such as God would keep us healthy, insurance invites diseases, wish for sickness to get claim benefits, and insurance should give good returns (like an investment) should be removed. If this misconception is not promptly addressed, SSP would be under the threat of financial sustainability due to adverse selection. Hence, target groups should be taught that health insurance is not an investment but risk management tool that provides financial protection against unforeseen consequences of ill health. The management and administrators of the programme have to build solidarity and mutual concern through awareness campaigns to enlarge the risk pool that includes healthy and rich. Besides, better understanding of claim procedure, documents required, network hospitals and the reasons for non-approval of the claim should be achieved.

This study reflects dissatisfaction with the coverage of health services because SSP excluded outpatient (OP) treatment and common ailments from coverage. The programme should consider the inclusion of OP services and some ailments in benefit package. Due to expensive health services, poor usually go to nearby clinics or resort to home medicine. By including OP services in benefit package, not only membership would improve but also they can avail services of doctors at OP departments of good hospitals. However, insurance generally provides indemnity upon illness that cripples the household financially such as chronic illness requiring admission. It is assumed that low cost OP services can be afforded by people. To prevent the drain of resources due to some ailments that requires either recurring or high cost treatment, certain illnesses are excluded. However, the management of SSP should consider the need of target population, discuss rationale for the benefit package, and encourage active participation by members to improve enrolment and success of the programme. A study by Dror and others (2007) have shown that illiterate rural communities can participate to design benefit package. At present, insured don’t participate in the management of the scheme other than discussions in their group meetings on issues related to hospitals and claim benefits. In addition, the study observed lack of clarity among non-renewed members on the pre-authorization procedure and network hospitals that deprived them of availing the benefits which reflects lack of information. Family support is a crucial factor for the participation of women in any developmental programme. There was lack of support from primary member of family such as husband. Not
only active participation in MFI activities was restricted but also SSP membership was withdrawn due to unclaimed benefits from SSP and lack of money. There is an urgent need to educate women as well as men and create awareness on the importance of insurance and its benefits.

**Conclusion**

There is a justification for the support of policymakers to MHI, an innovative health care financing mechanism aimed to mitigate iatrogenic poverty. To ensure sustainability, keeping in mind the study finding that inability to pay the premium excludes poor from insurance mechanism, greater role for government and the corporate philanthropy is advocated. Government or corporate donors can either provide grants to SSP or subsidize the premium through its contribution making the programme self-sufficient. Being embedded in micro finance programme, SSP can use the established rural network to penetrate into untapped areas resulting in ‘insurance inclusion’ in the line of ‘financial inclusion’. However, to meet the requirements of the target population, the programme has to make certain changes to its design to attract new members and retain current members every year which expands its membership base and enhances its sustainability. The programme has to conduct awareness programmes on health education and SSP to tackle the problem of poor understanding of the concepts of insurance principles. Future studies on enrolment issues in other micro health insurance schemes in India can be carried out to get more useful inputs in the development of policy related to MHI in India.

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