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Capacity Building for the Development of Health Insurance Systems in India

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HEALTH INSURANCE IN India is largely confined to the organised labour sector and central as well as state government employees. Only in recent years, non-governmental organisations have been trying to introduce voluntary health insurance schemes for the rural and informal sectors. These are largely donor-financed and limited in terms of coverage. There is a huge demand for adequate social protection systems, especially for the poor, but universal health insurance is still something to be dreamed of. Bringing about institutional change to the present, largely out-of-pocket and tax-financed system will depend on the awareness of policy makers and the public about the benefits of solidarity-based health insurance. Moreover, it will be necessary to develop client-focused products and new public-private cost sharing mechanism. Bringing in quality assurance and equity in access, bringing in incentives to control cost, and strengthening monitoring and control are key aspects, which would imply a reorientation of the roles and responsibilities of different stakeholders. In order to overcome these challenges, there is a tremendous need and demand for capacity building in the areas of health financing, health insurance and quality assurance.

The present paper is based on the findings of the study conducted by an expert mission consisting of Dr. Bernd Schram, Project Manager at GTZ, Bonn, Germany and Dr. P.R. Sodani, Associate Professor of Health System, Health Economics and Health Financing at Indian Institute of Health Management Research (IIHMR), Jaipur. The mission was conducted in India during October-November 2002 and authors visited various leading institutions and professionals in the country involved in the area of health insurance. The mission was planned and financially supported by the Public Health Division of InWent (International Training and Development), Germany.

There is a tremendous need for capacity building in the areas of health financing, health insurance and quality assurance. The suggested measures should include *human resource development, technical training* (conventionally and electronically provided), *institutional capacity building, research* and *consultancy*. However, the different types of health insurance which have recently been introduced, planned or taken into consideration in India makes it quite complex to identify common training needs. Broadly speaking, there

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are approaches "from above", where the state takes the initiative, and approaches "from below", were civil society groups or organisations are the leading force.

To illustrate this, the following health insurance "models" can be found in India: employees' state insurance scheme (ESIS); central government health scheme (CGHS); government health insurance scheme for the informal sector; community-based health insurance; NGO-based health insurance; cooperative-based health insurance; facility-based health insurance; occupational health insurance; and private health insurance. Besides this, there are micro finance institutions (MFIs), which are increasingly recognising the need to add insurance to their portfolio of financial services. As saving and credit programmes usually work with a large group of members, it seems possible to access the group insurance schemes for weaker sections of society of the insurance companies. There are also plans to sell insurance products through regional banks, e.g. the *Grameen* bank or NABARD (National Bank for Agriculture and Rural Development). However, the government has not made a decision yet to which extend it allows banks to provide insurances.

An assessment of training needs for health insurance development in India, conducted by the authors, revealed that there is a huge demand for training and dialogue programmes in particular in the following areas: a) basic principles and alternative concepts of health financing; b) basic principles and functions of solidarity-based health insurance systems; c) client-oriented health insurance product development; d) public-private partnership in health insurance development; e) health insurance management skills; f) professional health insurance techniques; g) learning from international experiences and good practices

Introducing a health insurance scheme in India implies a structural change from a system predominantly financed through government budget and out-of-pocket expenditure to a system increasingly financed through insurance contributions. Bringing about this change requires a sophisticated political dialogue at different levels with key stakeholders. Moreover, technical and management know how is required to secure a successful implementation. Depending on the preferred model of health insurance, the training and dialogue programmes need to be targeted to different groups which all play a crucial role in the transformation process. In abstract terms, three levels of intervention can be distinguished: a) the *policy level*, b) the *strategic level*, and c) the *operational level*. The possible target groups are: political decision makers, government executives, staff from regulatory authority (IRDA), managers and staff from insurance industry, executives and specialists of health insurance institutions, professionals and field staff of civil society organisations, health care providers (hospital managers, medical officers, general practitioners), and resource persons from academic and training institutions

At the *policy level*, the delivery of knowledge about health financing and health insurance has to go along with political advocacy and sensitisation for the need of health care reform. Likewise, the role of the government as

facilitator and regulator of health care delivery (rather than primary source of financing) has to be strengthened. This requires a shift in attitude and behaviour. In India, health insurance is sometimes misunderstood as "privatisation" of government functions. Yet, from the discussion we had, there is little doubt that it is the responsibility of the governments to establish and control a (legal) framework for action and assure quality services, not only with regards to government facilities, but in the private sector as well. Policy consultancy, seminars and conferences on national and international level, combined with intellectual input from good practices elsewhere, can help to develop a better understanding of the changing roles of each actor in the health care system. The dialogue with decision makers in the government and in the insurance sector should be taken up with the Insurance Regulatory Development Authority (IRDA). It is also suggested to carry out an extensive impact assessment of the different health insurance schemes that are currently being implemented. A standard methodology could be used to reveal their financial situation and sustainability, as well as to what extend the living conditions of the insured have actually improved through access to insurance services.

At the *strategic level,* it is necessary to inform relevant stakeholders about alternatives in health financing and health insurance, to bring together the different groups and develop public-private partnership. A new health financing system and innovative insurance products cannot be developed in isolation, neither by governmental nor by non-governmental actors. Since liberalisation of the insurance market in 1999 and the recent emergence of Third Party Administrators (TPAs), the private sector is in the health care system not only present as provider, but also as insurer and administrator. In addition, civil society organisations can deliver insurance services to their members as "brokers", "agents" or "mutuals". However, knowledge of insurance operations is a prerequisite for a proper provision of insurance services. NGOs, self-help groups and cooperatives do not yet have sufficient expertise in this field. This can lead to high-risk programmes that endanger the savings of the insured members and/or make poor population groups pay for (partial) risk coverage. On the other side, employees of insurance companies have little experience with dealing with NGOs and claims from poorer population groups. Awareness generating about the specific requirements of poor target groups is needed. New products, suitable to the needs of the masses, need to be developed between civil society groups, insurance companies, TPAs and health care providers. Similar, dialogue programmes between the public and private sector can help the government(s) to understand the needs of its population and take steps to satisfy them, while at the same time facilitating private actors' understanding of budget constraints, expectations and procedures of the government. Finally, one should not forget the Media, which is crucial in influencing public opinion and nourishing public debate about political reforms.

In general, capacity building for health insurance has to start with an ntation workshop for those people not yet familiar with the concepts of

health financing and health insurance. This is particular important at the *operational level,* since there is not much knowledge about this field in general. Health financing and health insurance are not part of the curricula of medical colleges, so obviously medical students and health professionals know little about it. We have come across only one health-financing course in the country, offered by the Indian Institute of Health Management Research (IIHMR) in Jaipur as a Management Development Programme. This is certainly not enough as it devotes only six days and covers apart from the basic concepts of health insurance, costing and cost analysis and other alternative methods of health financing. If a health insurance is to be introduced, the executives and specialists of the insurance institution or agency, health care providers and field staff in the community have to be trained. There is tremendous need for technical as well as management training regarding health insurance implementation. For instance, NGOs linking up for a group scheme with an insurance company have to carry out certain tasks for running the scheme (e.g. educating members about the scheme, enrolling and collecting premiums, paying up group's premium to the insurance company, processing claims, maintaining records). Setting up an organisational unit able to cope with these tasks is a big challenge for many organisations. The operational staff has to understand basic financial and management concepts as well as health insurance techniques. Moreover, community leaders and field level staff need to know how insurance works, the specifics of the scheme being offered, who is eligible, how the premium and benefits are structured and what is needed to fulfil all these tasks. Civil society groups with a large member network can play an important role in providing this kind of capacity building, especially with regards to the *field level,* which would be another tier in the concept.

The establishment of a *Centre for Health Insurance Competence (CHIC)* is another way of institutionalising health insurance competency and training activities. The so-called CHIC approach was developed by German Technical Cooperation (GTZ) as an answer to the perceived lack of managerial, technical and political know how of small-scale health insurances such as community-based schemes or mutual. CHIC is based under the assumption that it is neither necessary nor desirable to develop within each organisation the management capacity to run a health insurance scheme in a total autonomous manner. Smaller health insurance agencies may obtain this expertise from a higher-level institution. CHIC can provide these organisations with professional services, support, consultancy and training courses in whatever is essential for setting up, implementing and monitoring a health insurance scheme. A successful CHIC could not only increase health insurance efficiency, but also promote the concept of Social Health Insurance through policy advocacy.

It is also possible to offer standard modules as online or software-based training courses. This would be particularly relevant when the idea is to spread the courses to a wider audience. The combination of online and offline content deployment will help in better scalability and flexibility of training

delivery, and in the long term contribute to better cost efficiency. It has the additional advantage that people can update their knowledge base whenever they want to, without leaving their place of work.

The idea behind a "Think Tank" is to support policy makers through a network of specialists, both practical experts and academics working in the area of health insurance. In theory, the advantage of a *Think Tank* is that support can be given on a continuous basis rather than through one-time seminars, workshops or training courses. However, this presupposes that the experts from different institutions a) have similar ideas as to the basic concept of health insurance, b) are willing to join hands and contribute to a common goal, c) can be made available for this task when a particular demand comes up, and d) have signed a financial agreement with the funding agencies.

As a general note, one should not forget that the training and dialogue programmes could only be part of an overall concept to support the introduction of health insurance schemes in India. They can facilitate the process, but have to be accompanied by other activities to be fully effective. The complementary measures are, for example, research, consultancy and institutional capacity building. A careful planning requires feasibility or impact assessment studies which could be linked to training activities.

REFERENCE

- Schramm, B and P R Sodani (2003). Final Report: Expert Mission on Health Financing/Health Insurance Training Needs and Dialog Programmes in India. Submitted to InWent (International Training and Development), Germany. This is a feasibility studying preparation of InWent's programme package support for the reform of health financing and development of social insurance systems in Asia (India and Indonesia).