“Moral Hazards in mass health insurance policy: case of Rastriya Sawasthya Bima Yogna in Haryana”

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Dr Kamal Kapoor
Roll no. 19



International Institute of Health Management Research
New Delhi -110075
May,2010

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under the guidance of

Mr Neerav Agarwal
Associate Vice President
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International Institute of Health Management Research

New Delhi -110075

May,2010

Certificate of Internship Completion

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Dr Kamal Kapoor. has successfully completed his 3 months internship in our organization from February 1, 2010 to April 30, 2010. During this intern he has worked on Customer Service Manager and looked after the operation of RSBY in dist of Sonepat, Karnal and Kurukshetra under the guidance of me and my team at ICICI Lombard …… …… ..…… ……(any positive/negative comment)

We wish him/her good luck for his/her future assignments

(Signature)

_____(Name)

_____Designation

Certificate of Approval

The following dissertation titled " **Moral Hazards in mass health insurance policy: case of Rastriya Sawasthya Bima Yogna in Haryana.**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
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Certificate from Dissertation Advisory Committee

This is to certify that **Dr Kamal Kapoor** , a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled " **Moral Hazards in mass health insurance policy: case of Rastriya Sawasthya Bima Yogna in Haryana..**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Mr Harish Sihare
Assistant Professor
IIHMR
New Delhi
7 May 2010

Mr Neerav Agarwal
Associate Vice President
ICICI Lombard
New Delhi
6 May 2010

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At last I want to thank all employees of our empanelled hospital for RSBY, who appreciated me for my work and motivated me.

Dr. Kamal Kapoor

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List of Abbreviations

GWP:…… Gross Written Premium (GWP)

FFH ……..Fairfax Financial Holdings Limited (FFH

ICAI …….Institute of Chartered Accountants of India

RSBY……Rastriya Swasthya Bima Yojna

WHO……. World Health Organization

FFS……Fee-For-Service

PHC……Primary Health Care

NGO……...Non Government Organization

CHI ……Community Health Insurance

CGHS……Central Government Health Scheme

TPA……Third Party Administrators

OOPS……..Out Of Pocket Spending

HMO ……..……Health Managing Organization

ACCORD……Action for Community Organization, Rehabilitation and Development

SEWA:……Self-Employed Women's Association

GDP……Gross Domestic Product

NPP…….National Population Policy

NHP…….National Health Policy

NIAF……National Illness Assistance Fund

UNDP……..United national development programme

IRDA ……..Insurance Regulatory Development Authority.

GOI ……..……Government Of India

RMP……Rural Medical Practitioners

INTERNSHIP REPORT

ICICI Lombard is a 74:26 joint venture between ICICI Bank Ltd., India's second largest bank with $79 billion in assets and Fairfax Financial Holdings Ltd., a Canada based $26 billion diversified financial services company engaged in general insurance, reinsurance, insurance claims management and investment management. ICICI Lombard's success is the result of coming together of two of the most trusted names in the financial sector.

The company is the largest private sector general insurance company in India with a Gross Written Premium (GWP) of Rs 30,034 million for the 12 months ended March 31, 2007 with a market share of nearly 12.4% and compounded annual growth rate of over 84% in the last two years.

ICICI Lombard was adjudged as the most Customer Responsive Company in the Insurance category at the Economic Times Avaya Global Connect Customer Responsiveness Award 2006 and awarded the Gold Shield for "Excellence in Financial Reporting" by the ICAI (Institute of Chartered Accountants of India) for the year ended March 31, 2006. It was among the top three General Insurance Companies to be awarded the "General Insurance Company of the Year" at the 10th Asia Insurance Industry Awards.

The company has been assigned an iAAA rating by ICRA (an associate of Moody’s Investors Service) for highest claim paying ability and a fundamentally strong position. The prospect of meeting policyholders’ obligation is the best.

The company has over 4,770 personnel in 220 offices spread across 166 locations. From April – March 2007, the company issued over 3.1 million policies across India and settled over 5.9 lakh claims. The company has a claim disposal ratio of 96% (percentage of claims settled against claims reported) as on March 31, 2007.

Promoters

ICICI Bank

ICICI Bank is India's second-largest bank. ICICI Bank offers a wide range of banking products and financial services to corporate and retail customers through a variety of delivery channels and through its specialised subsidiaries and affiliates in the areas of investment banking, life and non-life insurance, venture capital and asset management. The Bank currently has subsidiaries in the United Kingdom, Russia and Canada, branches in United States, Singapore, Bahrain, Hong Kong, Sri Lanka, Qatar and Dubai International Finance Centre and representative offices in United Arab Emirates, China, South Africa, Bangladesh, Thailand, Malaysia and Indonesia. Our UK subsidiary has established branches in Belgium and Germany.

ICICI Bank's equity shares are listed in India on Bombay Stock Exchange and the National Stock Exchange of India Limited and its American Depositary Receipts (ADRs) are listed on the New York Stock Exchange (NYSE)

Fairfax

Lombard Canada Ltd, a group company of Fairfax Financial Holdings Limited, is one of Canada's oldest property and casualty insurers. It is a leading insurance management company responsible for providing insurance management services for all of the Lombard group's commercial, personal, and specialized insurance companies. Lombard Canada Ltd. has its head office in Toronto, Canada and has annual sales in excess of $977 million and is a wholly owned subsidiary of Fairfax Financial Holdings Limited (FFH on Toronto Stock Exchange). It has received an A- rating from A.M. Best Company and claims paying ability received an A+ rating from Duff & Phelps Credit Rating Co.

Board Members

- Chanda Kochhar, Chairperson

- R. Athappan, Director
- Sandeep Bakhshi, Director
- B.V. Bhargava, Director
- Dileep Choksi, Director
- N.S. Kannan, Director
- S. Mukherji, Director
- Chandran Ratnaswami, Director
- M.K. Sharma, Director
- H.N. Sinor, Director
- Bhargav Dasgupta, Managing Director & CEO

Corporate Profile

ICICI Lombard Corporate Highlights

- **Strong Parentage:** ICICI Lombard leverages ICICI Bank's strong brand equity, extensive distribution network and sound technological infrastructure to service customer needs. Lombard Canada assists on domain knowledge, product innovation, business processes based on cutting edge technology and international best practices in the insurance business.

- **Resourceful Customer Service:** ICICI Lombard services a wider foot-print of customers with its offices located in 127 cities across India. With a network of 3500 hospitals in 200 cities and around 1500 garages in 255 cities, ICICI Lombard offers cashless claim settlement to its customers. We also have an online customer support system which allows customers to track their claim status and facilitate quick response to service requests.

- **Strong Claims paying ability:** We have been assigned the iAAA rating, indicating highest claims paying ability. As of 2005-06, over 14,51,000 policies have been issued across India and over 2.4 lakh claims settled.

- **Comprehensive Products:** We have over 32 customised and innovative insurance solutions in the offering

Awards and Recognition

ICICI Lombard Auto Insurance has been rated highest in customer satisfaction by J.D. Power Asia Pacific in India among 11 auto insurance providers. The company has been conferred the Golden Peacock- Eco Innovation Award of 2009 for weather insurance and the Customer and Brand Loyalty award in the "Insurance Sector - Non-Life" at the 2nd Loyalty awards, 2009. It was awarded the 'General Insurance Company of the Year' at the 11th Asia Insurance Industry Awards. The company also won the NDTV Profit Business Leadership Award 2007 and was adjudged as the most Customer Responsive Company in the Insurance category at the Economic Times Avaya Global Connect Customer Responsiveness Award 2006. It has the Gold Shield for "Excellence in Financial Reporting" by the ICAI (Institute of Chartered Accountants of India) for the year ended March 31, 2006.

JD Power Asia Pacific Award

ICICI Lombard Ranks Highest in Customer Satisfaction among Auto Insurance Providers in India: J D Power Asia Pacific

World Business Leader Award 2010

ICICI Lombard GIC Ltd. conferred the 'World Business Leader' award at 'The Bizz 2010' awards held on April 2, 2010.

Golden Peacock- Eco Innovation Award of 2009 for weather insurance

ICICI Lombard has been conferred the Golden Peacock- Eco Innovation Award of 2009 for weather insurance.

Customer and Brand Loyalty Award 2010

ICICI Lombard wins the 'Customer and Brand Loyalty Award' in the 'Insurance Sector -

General' at the 3rd Loyalty Awards held on January 27, 2010.

General Insurance Company of the Year

11th Asia Insurance Industry Awards 2007, Singapore

ICICI Lombard becomes the first Indian insurance company to win this prestigious award.

NDTV Profit Business Leadership Award 2007

Conferred as leaders in General Insurance Category at the NDTV Profit Business Leadership Awards 2007 held at Delhi. These Awards honour business excellence. They are aimed at recognizing companies that have shown exceptional ability across industries and have nurtured excellence.

First in Customer Responsiveness

Economic Times Avaya Global Connect Customer Responsiveness Award 2006

ICICI Lombard bagged the maximum votes from customers in 2006, making it the most Customer Responsive Company in the Insurance sector.

Brand Leadership Award – 16th Asia Brand Congress, Taj Lands End, Mumbai

Awarded the Brand Leadership Award at the 16th Asia Brand Congress held at Taj Lands End, Mumbai from 26-27th September, 2007.

Best Housing Insurance 2006

Awarded the Best Housing Insurance in the Smart Living Awards by 360 degrees, a Times of India Group subsidiary, in Nov 2006.

Excellence in Financial Reporting

Awarded the Gold Shield for "Excellence in Financial Reporting" by the ICAI (Institute of Chartered Accountants of India) for the year ended March 31, 2006.

iAAA rating by ICRA

Assigned the iAAA rating by ICRA indicating highest claims paying ability and a fundamentally strong position

My role in Organisation :

I am working as Customer Service Manager- Health & Accident. My job includes:

- Fraud control
- Liasoning with government officials
- Reconciliation
- Meeting with customers and resolving their problems
- TPA management

My day to day job involves close co-ordination with empanel hospitals and to find out the problems they are facing ,visiting hospitals and villages to meet the patients and take feed back from them, to check the medical records to patients to find out whether they are in place or not and they match with the disease ,hospitals has claimed.

Another important part of the job is TPA management which involves to make sure that hospital get pre-auth in time and they receive their due payment with in stipulated TAT(turn around time)

Learning from the job:

- Aware among common person as well as health care providers regarding health insurance is till very low.
- Frauds and moral hazards are very prevalent
- Technology can play very important role in this fraud control
- No matter how much a technology is advanced, it can replace human intervention
- Maintaining relationship is the key to success in customer-centric industry like health insurance

ABSTRACT

Of all the risks facing poor households, health risks probably pose the greatest threat to their lives and livelihoods. A health shock thrusts health expenditure on a poor household precisely at a time when they can ill-afford it due to income shortfall resulting from the shock. Moreover, the uncertainty of the timings of illness and unpredictability of its costs

make financial provision for illness difficult for households receiving low and irregular income. Insurance is a suitable way to resolve this problem as insurance separates time of payment from time of use of health services for each member, and thereby makes possible demand for such services by its members who would not have otherwise been able to afford the cost. Health insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called *premium*.' In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. But in this world , nothing is perfect, everything has it's own weakness and one of most common weakness of insurance is moral hazard. Moral hazard arises because an individual or institution does not take the full consequences and responsibilities of its doings, and therefore has a tendency to act less carefully than it alternately would, leaving another party to hold some responsibility for the consequences of those actions. The moral hazard problem is of two kinds: ex ante moral hazard and ex post moral hazard problem. The ex ante moral hazard problem arises due to reduced care of health after joining a scheme. The ex post moral hazard problem arises due to over-consumption of medical services. The over-consumption may be the result of provider's behavior or due to patient's behavior

This project tries to identify the prevalence of moral hazard in a mass health policy i.e Rastriya Swasthya Bima Yogna(RSBY) and its relationship with age, income and gender. For selecting a non probability sampling technique i.e convenience sampling was used to shortage of time and money. 115 persons in district of Karnal, Kurukshetra and Sonepat , who were enrolled under RSBY and availed services at least once during the tenure of policy, were approached for these survey, Beside questionnaire, interviews of key informants were taken to collect the information. People who were either minor (as they are mostly not decision makers in the family) and the persons who were not in sound mental condition due to disease or drugs were exempted from this survey. The data was analyzed by using SPSS and Microsoft Excel. Study showed that availability of health insurance coverage significantly effect the behavior of beneficiaries. The same person who was happily receiving the treatment in a government hospital, will start preferring to private hospital when is covered under health insurance though he do not need to pay any amount in both the hospitals, he start asking for more services when he is covered under

health insurance plan as he do not need to pay extra for this excessive demand e.g Patients get hospitalized just because indoor treatment is free or it's more convenient .Many people forego the opportunity of getting a disease treated in early treatment as they need to pay from their own pocket for diagnostic and preventive therapies. This moral hazard is not limited to beneficiaries, it is also common with healthcare provider. Study also showed that most of the people are ready to pay extra in case preventive and promotive health services are also covered under this scheme.

Introduction

According to 61st NSS, 27.5 % population in India live below poverty line.(income below Rs 356.30/month in rural and Rs.538.60/month in urban area). Three fourth of Indian population live below or on subsistence level which means approx. 75-90% of their income goes on food & related consumption. An individual, who is hospitalized, spend more than

50% of his/her annual income on hospital bills. 24% of these patients fall below poverty line and this out of pocket health expenditure pushes 2.2% population below poverty every year. According to 52nd round of NSS 1995-96,approx.40% of population borrow or sell their assets to finance their hospitalization expenditure.NSS 17th showed that loan for health care to be number one cause for families, especially poor, getting in to indebtness

Direct public provision of health care services for the people lacking resources is only one of the ways of meeting their health care needs. This strategy was tried in the past under the belief that the poor are too poor to save and contribute towards meeting their health care needs. It is also argued that in a situation where the government is faced with limited resources from tax revenues (as is the case in most developing countries), supply will be constrained without cost recovery and a significant level of excess demand will prevail. In this circumstance, a user fee that relaxes the government's budget constraint would allow a higher level of provision of services, reducing the excess demand.

But now there is a growing realization that even the poor can make small, periodic contributions that can go towards meeting their health care needs (Zeller and Sharma 1998). As a result, *health insurance* is increasingly being recognized as a tool for financing health care provision in low-income countries. In 1987, the World Bank strategy as outlined in the "Agenda for Reform"2 called for increased private sector provision of health care, user charges, and health insurance; the World Bank explicitly recommended user fees. Proponents of user fees argue that in situations of free public provision of health care, where financing is also largely public, it is likely that the latter case prevails and there is 'excessive' use of public facilities arising out of moral hazard. Therefore user fees, which usually represent a small fraction of the true cost of production, are justified in order to prevent this excess use (inappropriately high consumption).

Insurance separates time of payment from time of use of health services for each member, and thereby makes possible demand for such services by its members who would not have otherwise been able to afford the cost. Insurance is particularly beneficial to the poor who often bear high indirect costs of treatment due to their limited ability to mitigate risk on account of imperfect labour and credit markets.

Health Insurance

Health insurance in a narrow sense would be ‘an individual or group purchasing health care coverage in advance by paying a fee called *premium*.’ In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

(1) Voluntary health insurance schemes or private-for-profit schemes;

(2) Employer-based schemes;

(3) Insurance offered by NGOs / community based health insurance, and

(4) Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).

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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 Mediclaim (Krause 2000). From an accounting perspective, it is treated as a branch of Mediclaim 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 Mediclaim, 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 coinsured for Rs. 50 ($1.10).

In 2003, on an initiative by the Minister of Finance, state-run insurance companies introduced a health insurance product to protect five to ten million policyholders. **Universal Health Insurance was** 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 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 was 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

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). These employer-based systems, offered by the postal service or railway for example, are estimated to insure 20 to 30 million persons

Micro insurance

India is a hot spot for the development of micro insurance. Many micro-schemes have emerged in recent years, but there are some older schemes as well. The fast development of the micro insurance 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 subsidized by the government

Insurance offered by NGOs / community-based health insurance

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore

not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits. Community-based schemes are typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources *(International Labour Office Universities Programme 2002 as quoted in Ranson K & Acharya A,2003).* Such schemes are generally run by trust hospitals or nongovernmental organizations (NGOs). The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with the for profit insurers for the purchase of custom designed group insurance policies. However, the coverage of such schemes is low, covering about 30-50 million (*Bhat, 1999*). A review by Bennett, Cresse et al. *(as quoted in Ranson K & Acharya A, 2003)* indicates that many community-based insurance schemes suffer from poor design and management, fail to include the poorest-of-the poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes. Below table provides an overview of some non-profit social insurance schemes. Some of the schemes are described below *(Ranson K & Jowett M, 2003).*

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Table 3. *Non-profit social insurance schemes in India*

Name	Location	Members	Type of insurance
1. ACCORD/ ASHWINI Health Insurance Scheme	Tamil Nadu (Gudalur)	7 356 (1997)	Health Insurance (with NIA)
2. Aga Khan Health Services3	Gujarat (Sidhpur)	40 000 (1997)	Health insurance
3. Apollo Hospital Association (AHA)	Tamil Nadu (Madras)	10 000 (1995)	Health Insurance (with GIC)
4. ASSEFA (Association of Sarva Sewa Farms)	Tamil Nadu (Madurai)	N.N.	Cattle Insurance Health Insurance
5. Cooperative Development Federation (CDF)	Andhra Pradesh (Hyderabad)	26 000	Death Relief Fund (Life Insurance)
6. Goalpara Cooperative Health Society	West Bengal (Shantiniketan)	1 247 (1997)	Health Insurance
7. Kottar Social Service Society (KSSS)	Tamil Nadu (Kanyakumari)	34 000	Health Insurance
8. Mallur Health Cooperative	Karnataka	7 000 Health	Insurance
9. Mathadi Hospital Trust	Maharashtra (Bombay/Mumbai)	150 000	Health Insurance
10. Medinova Health Card Scheme	West Bengal (Calcutta)	35 000	Health Insurance
11. Navsarajan Trust	Gujarat	10 000	Health Insurance (with NIA) Accidental Insurance (with LIC) Nutrition Legal Aid Drugs Fight Against Corruption
12. New Life	Tamil Nadu	N.N.	Health Insurance
13. Organization for Development of People (ODP)	Tamil Nadu (Mysore)	1 137	Health Insurance Accidental Insurance (with NIC)

Name	Location	Members	Type of insurance
14. Pragati Thrift and Credit Society	–	410	Death Relief Fund
15. Raigarh Ambikapur Health Association (RAHA) Medical Insurance Scheme	Madhya Pradesh (Raigarh District)	75 000	Health Insurance
16. Saheed Shibsankar Saba Samity (SSSS)	West Bengal (Burdwan)	6 800	Health Insurance
17. Seba Cooperative Health Society	West Bengal (Calcutta)	3 000 families	Health Insurance (with GIC)
18. Self Employed Women's Association (SEWA)	Gujarat (Ahmedabad)	40,000	Integrated Insurance Scheme Health Insurance Life Insurance (with LIC) Accident (with NIA) Asset Insurance Maternity Benefit
19. Kasturba Hospital Scheme, Sewagram	Maharashtra (Wardha District)	19 457 (1997)	Health Insurance
20. Social Work and Research Centre (SWRC) (defunct?)	Rajasthan (Ajmer)	20 000	Health Insurance
21. Society for Promotion of Area Resources Centre (SPARC)	Maharashtra (Bombay/Mumbai)	1 200 couples	Health Insurance Accident Housing (with OIC)
22. Students Health Home	West Bengal (Calcutta)	550 000	Health Insurance
23. Tribhuvandas Foundation	Gujarat (Anand)	800 000	Health Insurance
24. Trivandrum District Fishermen's Federation (TDFF)	Kerala (Thiruvananthapuram)		Craft & Gear Fund (loan basis) Contingency Fund (death, accidents, loss of work)

Name	Location	Members	Type of insurance
25. Urmal Rural Health and Research Development Trust (defunct?)	Rajasthan (Bikaner & Jodhpur)	N.N.	Health Insurance
26. Voluntary Health Services Medical Aid Plan	Tamil Nadu	160 000	Health Insurance

Source: Patrick Krause (2000), 'Non-profit Insurance Schemes for the Unorganized Sector in India', Social Policy Division 42, Working Papers No. 22 e, GTZ

Some examples of community-based health insurance schemes are discussed herein.

Self-Employed Women's Association (SEWA), Gujarat: This scheme established in 1992, provides health, life and assets insurance to women working in the informal sector and their families. The enrolment in the year 2002 was 93 000. This scheme operates in collaboration with the National Insurance Company (NIC). Under SEWA's most popular policy, a premium of Rs 85 per individual is paid by the woman for life, health and assets insurance. At an additional payment of Rs 55, her husband too can be covered. Rs 20 per member is then paid to the National Insurance Company (NIC) which provides coverage to a maximum of Rs 2 000 per person per year for hospitalization. After being hospitalized at a hospital of one's choice (public or private), the insurance claim is submitted to SEWA. The responsibility for enrolment of members, for processing and approving of claims rests with SEWA. NIC in turn receives premiums from SEWA annually and pays them a lumpsum on a monthly basis for all claims reimbursed. (Ranson K & Acharya A, 2003).

Another CBHI scheme located in Gujarat, is that run by the **Tribhuvandas Foundation (TF),** Anand. This was **e**stablished in 2001, with the membership being restricted to members of the AMUL Dairy Cooperatives. Since then, over 1 00 000 households have been enrolled under this scheme, with the TF functioning as a third party insurer.

The Mallur Milk Cooperative in Karnataka established a CBHI scheme in 1973. It covers 7 000 people in three villages and outpatient and inpatient health care are directly provided.

A similar scheme was established in 1972 at **Sewagram**, Wardha in Maharashtra. This scheme covers about 14 390 people in 12 villages and members are provided with outpatient and inpatient care directly by Sewagram.

The **Action for Community Organization, Rehabilitation and Development (ACCORD),** Nilgiris, Tamil Nadu was established in 1991. Around 13 000 *Adivasis* (tribals) are covered under a group policy purchased from New India Assurance

Another scheme located in Tamil Nadu is **Kadamalai Kalanjia Vattara Sangam (KKVS),** Madurai. This was established in 2000 and covers members of women's self-help groups and their families. Its enrolment in 2002 was around 5 710, with the KKVS functioning as a third party insurer.

The Voluntary Health Services (VHS), Chennai, Tamil Nadu was established in 1963. It offers sliding premium with free care to the poorest. The benefits include discounted rates on both outpatient and inpatient care, with the VHS functioning as both insurer and health careprovider. In 1995, its membership was 124 715. However, this scheme suffers from low levels of cost recovery due to problems of adverse selection.

Social Insurance or mandatory health insurance schemes or government run schemes (namely the ESIS, CGHS)

Social insurance is an earmarked fund set up by government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income (and hence ability to pay) rather than related to health risk. The benefit packages are standardized and contributions are earmarked for spending on health services

The government-run schemes include the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS).

Table 4. *Public insurance schemes*

	ESIS (Employees State Insurance Scheme)	CGHS (Central Government Health Scheme)
Contribution	Employees: 4.75% of wages. Employers: 1.75% of wages. All contributions are deposited by the employer. State governments contribute a minimum of 12.5 %on ESIS expenditures in their respective States (Garg 1999b, p. 30). See also section 59A (Govt. of India, 1999g, pp. 51-52)	Pay/pension Contribution (Rs/month) (Rs/month) <3,000 15 3001–6000 40 60001–10000 70 10001–15000 100 >15000 150 The bulk of resources (85%) come from general revenues of the Central Government (Garg 1999b, p. 34)
Reimbursement	Does not allow reimbursement of medical treatment outside of allotted facilities. For example, the Employees State Insurance Act 1948 states that entitlement to medical benefits does not entitle the insured to 'claim reimbursement for medical treatment. except under regulations' (Govt. of India, 1999g, p. 50) and ESI (General) Regulations, (Govt. of India, 1999g, p. 156)	1. Reimbursement of consultation fee, for up to four consultations in a total spell of ten days (on referral) 2. Cost of medicines 3. Charges for a maximum of ten injections. Reimbursement for specified diseases or ailments
Entitlement	Depending on 'allotment' as per the ESI Act 1.Outpatient medical care at dispensaries or panel clinics, 2. Consultation with specialist and supply of special medicines and tests in addition to outpatient care; 3. Hospitalization, specialists, drugs and special diet. 4. Cash benefits: Periodical payments to any insured person in case of sickness, pregnancy, disablement or death resulting from an employment injury.	1. First-level consultation and preventive health care service through dispensaries and hospitals under the scheme 2. Consultation at a CGHS dispensary / polyclinic or CGHS wing at a recognized hospital. 3. Treatment from a specialist through referral, emergency treatment in private hospitals and outside India.
Eligibility	Employees (and dependants) working in establishments employing ten or more persons (with power) or twenty or more persons (without power) and earning less than Rs. 6 500 per month. (Garg 1999a, p.85)	Employees of the Central Government (excepting railways, Armed Forces pensioners and Delhi Administration), pensioners, widows of Central Government employees, Delhi Police employees, Defence employees and dependants residing in 24 specified locations (See Govt. of India, various publications)

Reproduced from Mahal A (2001), 'Assessing Private Health Insurance in India: Potential Impacts and Regulatory Issues', Discussion Paper Series, No. 16, National Council of Applied Economic Research, New Delhi. p. 35

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Other Government Initiatives

Apart from the government-run schemes, social security benefits for the disadvantaged groups can be availed of, under the provisions of the Maternity Benefit (Amendment) Act 1995, Workmen's Compensation (Amendment) Act 1984, Plantation Labour Act 1951,Mines Labour Welfare Fund Act 1946, *Beedi* Workers Welfare Fund Act 1976 and Building and other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996

The Government of India has also undertaken initiatives to address issues relating to access to public health systems especially for the vulnerable sections of the society. The National Health Policy 2002 acknowledges this and aims to evolve a policy structure, which reduces such inequities and allows the disadvantaged sections of the population a fairer access to public health services. Ensuring more equitable access to health services across the social and geographical expanse of the country is the main objective of the policy. It also seeks to increase the aggregate public health investment through increased contribution from the Central as well as state governments and encourages the setting up of private insurance instruments for increasing the scope of coverage of the secondary and tertiary sector under private health insurance packages. The government envisages an increase in health expenditure as a % of GDP from existing 0.9% to 2.0 % by 2010 and an increase in the share of central grants from the existing 15% to constitute at least 25% of total public health spending by 2010. The State government spending for health in turn would increase from 5.5% to 7% of the budget by 2005, to be further increased to 8% by 2010. The National Population Policy (NPP) 2000, envisages the establishment of a family welfare-linked health insurance plan. As per this plan, couples living below the poverty line who undergo sterilization with not more than \ two living children would be eligible for insurance. Under this scheme, the couple along with their children would be covered for hospitalization not exceeding Rs 5 000 and a personal accident insurance cover for the spouse undergoing sterilization. The Institute of Health Systems (IHS), Hyderabad has been entrusted the responsibility of operationalizing the mandate of the NPP 2000. The initial scheme proposed by the HIS was discussed at a workshop in June 2003.

The consensus at the meeting was that the scheme, needed further improvement prior to its implementation even as a pilot project.

The Tenth Five Year Plan (2002-07) - also focused on exploring alternative systems of health care financing including health insurance so that essential, need-based and affordable health care is available to all. The urgent need to evolve, implement and evaluate an appropriate scheme for health financing for different income groups is acknowledged. In the past, the government has tried to ensure that the poor get access to private health facilities through subsidy in the form of duty exemptions and other such benefits. Social health insurance for families living below the poverty line has been suggested as a mechanism for reducing the adverse economic consequences of hospitalization and treatment for chronic ailments requiring expensive and continuous care. The government also offers assistance by way of Illness Assistance Funds, which have been set up by the Ministry of Health and Family Welfare at the national level and in a few states. State Illness Assistance Funds exist in Andhra Pradesh, Bihar, Goa, Gujarat, Himachal Pradesh, Jammu and Kashmir, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Mizoram, Rajasthan, Sikkim, Tamil Nadu, Tripura, West Bengal, NCT of Delhi and UT of Pondicherry. A National Illness Assistance Fund (NIAF) was set up in 1997, with the scheme being reviewed in January 1998. Through this, three Central Government hospitals and three national-level institutes have been sanctioned Rs 10 00 000 each at a time from the NIAF to provide immediate financial assistance to the extent of Rs 25 000 per case to poor patients living below the poverty line and who are undergoing treatment in these hospitals / institutions. Thereafter the scheme has been extended to few other institutes across the country and provides Rs 25 000 – Rs 50 000 per case.

Health insurance initiatives by State Governments

In the recent past, various state governments have begun health insurance initiatives. For instance, the Andhra Pradesh government is implementing the *Aarogya Raksha* Scheme since 2000, with a view to increase the utilization of permanent methods of family planning by covering the health risks of the acceptors. All people living below the poverty line and those who accept permanent methods of family planning are eligible to be covered

under this scheme. The Government of Andhra Pradesh pays a premium of Rs 75 per acceptor. The benefits to be availed of, include hospitalization costs up to Rs. 4000 per year for the acceptor and for his / her two children for a total period of five years from date of the family planning operation. The coverage is for common illnesses and accident insurance benefits are also offered. The hospital bill is directly reimbursed by the Insurance Company, namely the New India Assurance Company.

The Government of Goa along with the New India Assurance Company in 1988 developed a medical reimbursement mechanism. This scheme can be availed by all permanent residents of Goa with an income below Rs 50 000 per annum for hospitalization care, which is not available within the government system. The non-availability of services requires certification from the hospital Dean or Director Health Services. The overall limit is Rs 30 000 for the insured person for a period of one year. A pilot project on health insurance was launched by the Government of Karnataka and the UNDP in two blocks since October 2002. The aim of the project was to develop and test a model of community health financing suited for rural community, thereby increasing the access to medical care of the poor. The beneficiaries include the entire population of these blocks. The premium is Rs 30 per person per year, with the Government of Karnataka subsidizing the premium of those below poverty line and those belonging to Scheduled Castes/ Scheduled Tribes. This premium entitles them to hospitalization coverage in the government hospitals up to a maximum of Rs 2 500 per year, including hospitalization for common illnesses, ambulance charges, loss of wages at Rs. 50 per day as well as drug expenses at Rs 50 per day. Reimbursements are made to an insurance fund which has been set up by the NGO / PRI with the support of UNDP. The Government of Kerala is planning to launch a pilot project of health insurance for the 30% families living below the poverty line. The scheme would be associated with a government insurance company. Currently, negotiations are under way with the IRA to seek service tax exemption. The proposed premium is Rs 250 plus 5% tax. The maximum benefit per family would be Rs 20 000. The amount for the premium would be recovered from the drug budget (Rs 100), the PRI (Rs 100) and from the beneficiary (Rs 62.50) while the benefits available would include cover for hospitalization, deliveries involving surgical procedures (either to the mother or the newborn). Instead of

payment by the beneficiary, Smart Card facility would be offered. This scheme would be applicable in 216 government hospitals.

Rashtriya Swasthya Bima Yojna (RSBY)

Rashtriya Swasthaya Bima Yojna is a Central Government Scheme announced by the Prime Minister Manmohan Singh on the previous year's Independence Day (August 15, 2007). It is a new health insurance scheme for the Below Poverty Line (BPL) families in the unorganized sector. It was formally launched on October 1, 2007.

The objective of RSBY is to provide the insurance cover to below poverty line (BPL) households from major health shocks that involve hospitalization.

The majority of the financing, about 75 per cent, is provided by the Government of India (GOI), while the remainder is paid by the state government. State governments engage in a competitive bidding process and select a public or private insurance company licensed to provide health insurance by the Insurance Regulatory Development Authority (IRDA). The technical bids submitted must include a number of elements as per GOI requirements. The insurer must agree to cover the benefit package prescribed by GOI through a cashless facility that in turn requires the use of smart cards which must be issued to all members. This requires that a sub-contract be arranged with a qualified smart card provider. The insurer must also agree to engage intermediaries with local presence such as NGOs etc. in order to provide grassroots outreach and assist members in utilizing the services after enrolment. The insurer must also provide a list of empanelled hospitals that will participate in the cashless arrangement. These hospitals must meet certain basic minimum requirements (e.g., size and registration) and must agree to set up a special RSBY desk with smart card reader and trained staff. The list should include public and private hospitals.

The financial bid is essentially an annual premium per enrolled household. The insurer is compensated on the basis of the number of Smart Cards issued, i.e. households covered. Each contract is specified on the basis of an individual district in a state and the insurer

agrees to set up an office in each district where it operates. While more than one insurer can operate in a particular state, only one insurer can operate in a single district at any given point in time. The hardware and software specifications laid down by GOI imply inter-operability across districts and states.

With a view to provide security to the beneficiaries in terms of the charges levied for a particular treatment and to standardize the cost of each medical procedure, it was found necessary to list out the medical procedures and the cost thereof. However, the cost of each medical procedure is not mandatory for the State which can negotiate it separately with the insurance company who in turn would enter into a contract with the network hospitals accordingly. However, the States have been mandated to fix some cost. There is, therefore, no uniformity mandated throughout the country but the cost has to be fixed in each State making use of the suggestions given by the Central Government.

The OPD facilities are not covered under this scheme. However, OPD consultation is free. Beyond consultation, if any expenditure is incurred in the OPD, which does not lead to hospitalization, will be met by the beneficiaries. Common exclusions have been listed out in the detailed Guidelines. These common exclusions include:

- Conditions that do not require hospitalization
- Congenital external diseases
- Drug and Alcohol Induced illness
- Sterilization and Fertility related procedures
- Vaccination
- War, Nuclear invasion
- Suicide
- Naturopathy, Unani, Siddha, Ayurveda

Moral Hazards

Insurance market failure stems from adverse selection and moral hazard. Adverse selection means that the client joins insurance only when there is a problem, and the insurer is unable to restrict this because of information asymmetry (the client knows something that s/he will not tell the insurer). **Moral hazard** occurs when a party insulated from risk may behave differently than it would behave if it were fully exposed to the risk, it means that clients will use services more than necessary because the services will be paid for by the insurance. Moral hazard arises because an individual or institution does not take the full consequences and responsibilities of its doings, and therefore has a tendency to act less carefully than it alternately would, leaving another party to hold some responsibility for the consequences of those actions. For example, a person with insurance against automobile theft may be less cautious about locking his or her car, because the negative consequences of vehicle theft are (partially) the responsibility of the insurance company.
Moral hazard problem is of two kinds: ex ante moral hazard and ex post moral hazard problem. The ex ante moral hazard problem arises due to reduced care of health after joining a scheme. The ex post moral hazard problem arises due to over-consumption of medical services. The over-consumption may be the result of provider's behavior or due to patient's behavior. When it comes to providing health insurance to the low income people through micro-insurance we argue that it is the ex ante rather than ex post moral hazard problem that is dominant and serious.

In health care, these moral hazards mean patients do not hold themselves accountable for finding the quality of care they desire at a price that makes sense. Instead, patients often rush for more health care believing that more care is better care; or to specialists because this means more competent care; or to more tests because this translates to more comprehensive results; and finally to more drugs and more treatments because these mean a longer, happier life. And patients do so because they believe their care is "free." Due to the set up of the current "free" care healthcare system, patients are shielded from the actual costs of care, so they do not carefully consider these costs when assessing care.

The moral hazard problem is of two kinds: ex ante moral hazard and ex post moral hazard problem. The ex ante moral hazard problem arises due to reduced care of health after joining a scheme. The ex post moral hazard problem arises due to over-consumption of medical services. The over-consumption may be the result of provider's behavior or due to patient's behavior. Moral hazard" is the term economists use to describe the fact that insurance can change the behavior of the person being insured. E.g If a person gets a chance to eat as many ice creams as he wants and he gets an insurance cover against the risk caused by excessive consumption of ice cream, he will most likely consume more ice creams than he would have otherwise.

In 1968, the economist Mark Pauly argued that moral hazard played an enormous role in medicine, and, as John Nyman writes in his book "The Theory of the Demand for Health Insurance," What Nyman is saying is that when insurance company requires to make co-payment for a visit to the doctor, or when y plan includes deductible, it's not simply an attempt to share of health costs. It is an attempt to make use of the health-care system more efficient. Making one responsible for a share of the costs, the argument runs, will reduce moral hazard. As health resources are scare, treatment of persons who are not in real need of treatment is done on the cost of people who don't have any insurance but in real need to treatment..

Literature Review:

When a person experiences a bad shock to health, their medical expenses typically rise and their contribution to household income and home production (e.g. cooking or childcare) declines (e.g. Wagstaff and Doorslaer, 2003; Gertler, Levine & Moretti, 2003; Gertler and Gruber, 2002). According to the WHO, "Each year, approximately 150 million people experience *financial catastrophe*, meaning they are obliged to spend on health care more than 40% of the income available to them after meeting their basic needs." (WHO Factsheet N°320, 2007)

Low income and high medical expenses can also lead to debt, sale of assets, and removal of children from school, especially in poor nations. A short-term health shock can thus contribute to long-term poverty (e.g. Van Damme et al, 2004; Annear et al, 2006). At the same time, because households often cannot borrow easily, they may instead forego high-value care. When they do access care it will often be of low quality (Das, Hammer and Leonard, 2008), which can lead to poor health outcomes.

Theory suggests that health insurance can address some of these problems. By covering the cost of care after a health shock, insurance can help to smooth consumption, reduce asset sales and new debt, increase the quantity and quality of care sought, and can improve health outcomes.

Several studies have examined the effects of the very large Medicare (for those over 65) and Medicaid (for the poor and near-poor) insurance programs in the United States. Currie and Gruber (1996a, 1996b & 1997) study how the variable timing of the expansion of Medicaid across states affected children and pregnant women. Both groups increased doctor and hospital usage in states where Medicaid was first to expand, as compared to states where the program was enacted later.

Lichtenberg (2002) and Card, Dobkin and Maestas (2007) study the effect of Medicare by comparing health and health care outcomes of people just below 65 (many of whom lack health insurance) to outcomes of those just over 65 (all of whom are covered by Medicare). Both papers found that the group with more insurance received more care and had better health outcomes (although the reductions in mortality were often not statistically

significant in the Card, et al. study). Finkelstein (2005) finds that health care utilization increased fastest in areas where Medicare caused the largest increase in health insurance coverage.

The extent of adverse selection or positive selection into insurance has important repercussions for an insurance provider's ability to cover its costs. Standard insurance theory predicts that insurance markets will suffer from adverse selection, which occurs when less healthy people or people who are more risky with their health are more willing to purchase health insurance because they know that the amount they spend on healthcare will be larger than the premium they will pay. (e.g., Rothschild and Stiglitz 1976; Akerlof, 1970) Voluntary health insurance cannot be financially sustainable if adverse selection is severe, since only the most costly patients would find it worthwhile to purchase insurance, and premium levels will not be able to cover the high costs of care.

Non-experimental studies from developing countries sometimes find enrollment to be more common in households with chronically sick members, evidence of adverse selection (e.g. Wagstaff et al., 2007)

The RAND Health Insurance Experiment (HIE): The RAND HIE, conducted during the late 1970s and early 1980s in six U.S. communities, was the most expensive social experiment ever performed in the United States. It assigned participants at random to insurance plans that differed by cost-sharing parameters: some participants were assigned on to the free fee-for-service (FFS) plan; some were assigned to pay 25 percent of their health care bill with a maximum of $1,000 in out-of-pocket spending, receiving care for free thereafter; some were assigned to a 50 percent coinsurance policy with the same $1,000 stop-loss provision; and some were assigned to a 95 percent coinsurance policy with the $1,000 stop-loss provision. Others were assigned to an "individual deductible" plan with a 95 percent coinsurance rate for outpatient care up to a maximum of $150 for an individual and $450 for a family, and a 0 percent coinsurance rate for inpatient care. The lessons of the RAND HIE were (1) participants consumed less health care in plans with cost sharing than in the free FFS plan but (2) this reduction in health care consumption "had little or no measurable effect on the health status of the average adult"

In 1968, the economist Mark Pauly argued that moral hazard played an enormous role in medicine, and, as John Nyman writes in his book "The Theory of the Demand for Health Insurance," What Nyman is saying is that when insurance company requires to make co-payment for a visit to the doctor, or when y plan includes deductible, it's not simply an attempt to share of health costs. It is an attempt to make use of the health-care system more efficient. Making one responsible for a share of the costs, the argument runs, will reduce moral hazard. As health resources are scare, treatment of persons who are not in real need of treatment is done on the cost of people who don't have any insurance but in real need to treatment.

Research problem:

This project has been made on the topic on **"Moral Hazards in mass health insurance policy: case of Rastriya Sawasthya Bima Yogna in Haryana**

Objective of this study are:

To find out the prevalence of changed behavior of insured person under RSBY

To find an alternate which can be more beneficial for both insurance company and beneficiaries

Research problem and research questions:

Under Rastriya Swasthya Bima Yogna, only the indoor treatment is covered. It does not cover conditions which do not require hospitalization, except few day care procedures. Many diagnostic procedures and preventive procedure which do not require hospitalization are not covered in this policy. As OPD services are not covered in this policy , it has been observed that many time patient forego many diagnostic and preventive procedures and many time insist hospitalization even when the condition can be managed well on OPD basis. Foregoing early preventive procedure many time lead to serious conditions demanding more complex & costly treatment, which is harmful for both insurance companies as well as beneficiaries' .Similarly excessive demand of health services produces inefficiencies in the system. This study tries to find out the real cause of this excessive demand and change in behavior and also tries to find out an alternate to this condition.

Hypothesis 1 :That health insurance significantly change the behavior of beneficiaries .They start preferring private hospitals, when they are covered by health insurance.

Hypothesis 2: This change in behavior is not related to age, gender or income level. This change is universal

Hypothesis 3: If preventive and promotive health services are covered in the insurance scheme, more and more people will like to go for these services leading to better health of general population.

Hypothesis 4: People would like to pay more for Smart card (health insurance), if this scheme also covers OPD, preventive and diagnostic services

Research Design

Descriptive Research: - Descriptive research includes surveys and fact finding enquiries of different kinds. The major purpose of descriptive research is description of state of affairs as it exists at present. The main characteristic of this method is that the researcher has no control over the variables; he can only report what has happened or what is happening

Sampling Design

- Non Probability
- Convince Sampling

Population: BPL population enrolled under RSBY in District of Karnal, Kurukshetra and Sonepat (above 18 year age) and availed the in-door services at least once under this scheme

- Doctors working in empanelled hospitals for RSBY

Sample Size:

113 persons were approached, out of these responses were not collected from 23 persons, as they are either below 18 years of age or they are not in sound mental condition due to disease or drugs.

Unstructured interviews were conducted with more than 25 doctors and paramedical staff working in empanelled hospitals

DATA COLLECTION

Instrument: Questionnaire

Data Collection Method: Interrogation through Personal Interview.

Data analysis: Data was analyze through SPSS and Excel Sheet using descriptive studies with t test, frequency table ,correlation study, graph and charts

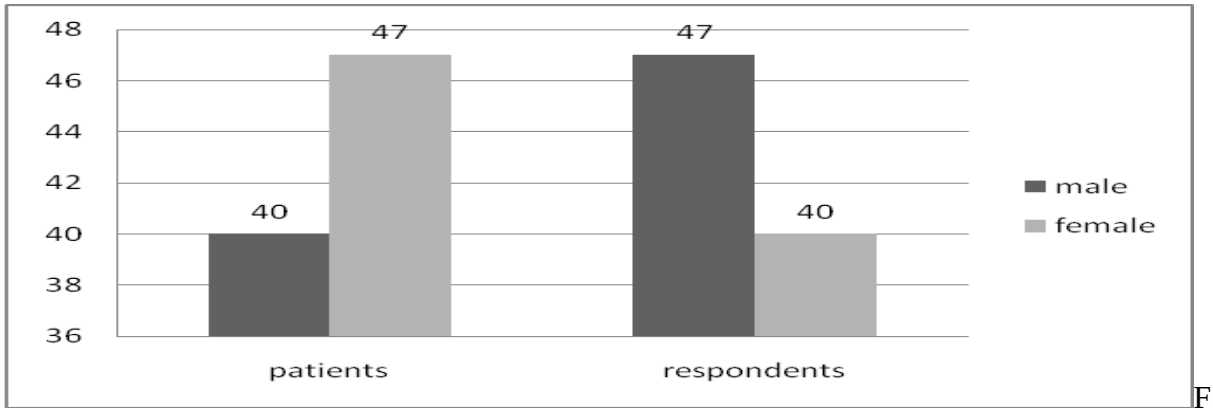
LIMITATIONS OF THE RESEARCH

1. Limited knowledge of the researcher in the field of research may lead to Interpretation errors.
2. The research was based on primary collection of data through Structured Schedule, so there may be chances of human error and biasness.
3. Limited knowledge of local rural language may result in to few wrong interpretations
4. As associated with every project, time and money were the major limitations with project.
5. The unstructured interviews were purely based on verbal meetings and may be influenced by unprecedented factors

Data Analysis

Respondent's profile:

In this study, responses from 87 patients were collected , out of which 47 were females and 40 were males. In few condition ,patient were not in condition to respond properly in such cases responses were taken from adult attendants, out of 87 respondents 47 were males and 40 were females



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Fig 1: gender profile of respondents and patients

Maximum number of respondents were in age group of 31-40 years of age(35%), followed by 51-60 years(23%), 41-50 years(21%) and above 60 years(8 %)

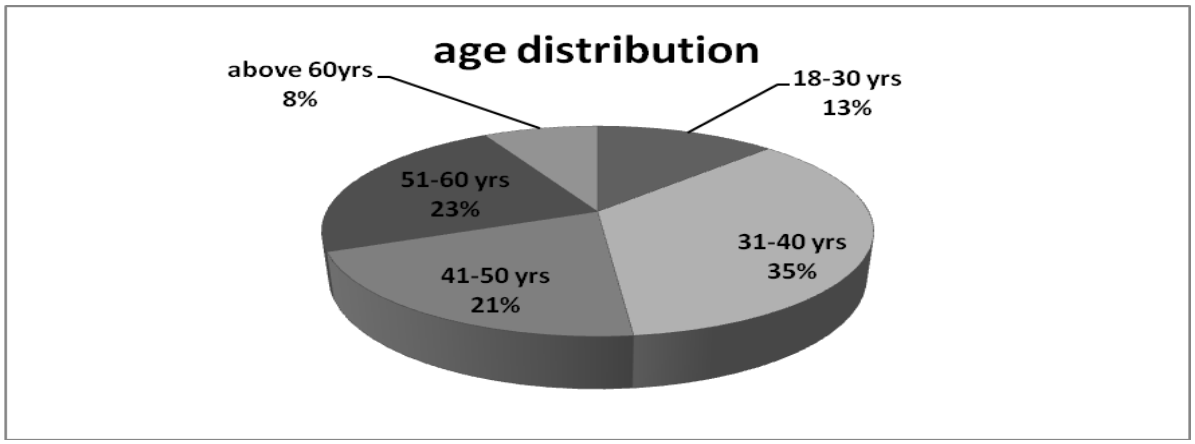


Fig 2: age distribution of respondents

Nearly 1/2 of the respondents i.e 45 % had annual income 20001-30000 Rs /annum, 30% had income more than 30000/annum, while 7% & 18 % were in category of less than Rs 10000 and 10001-20000 Rs respectively.

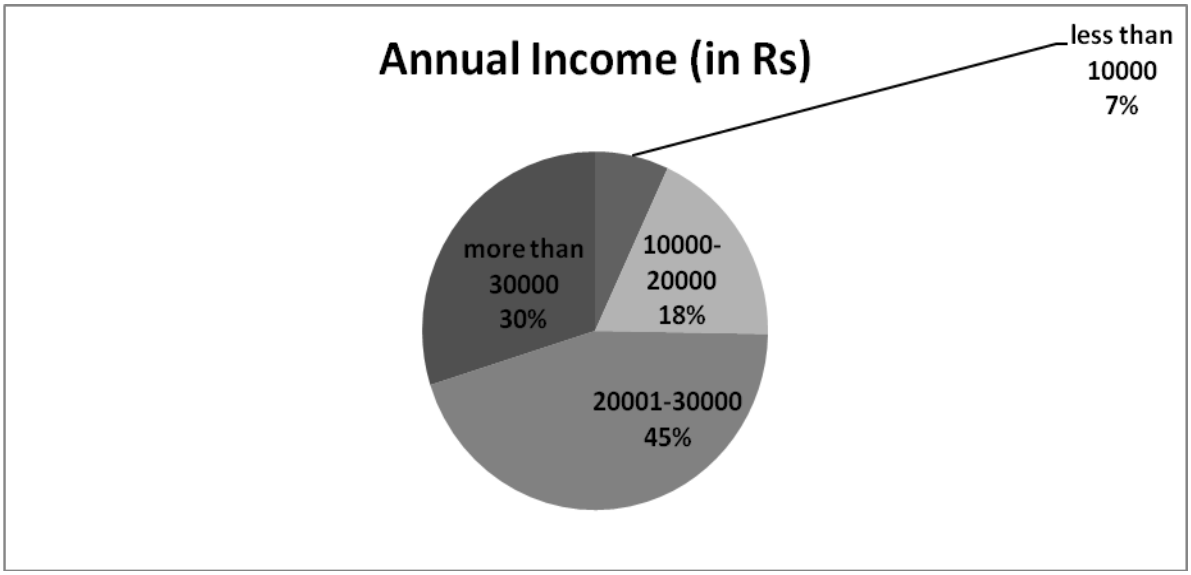


Fig 3: income of respondents

Study showed the chronic diseases are much more prevalent in insured population. Two third of respondent i.e 64.4 % were suffering from chronic ailments like Hernia, hemorrhoids,

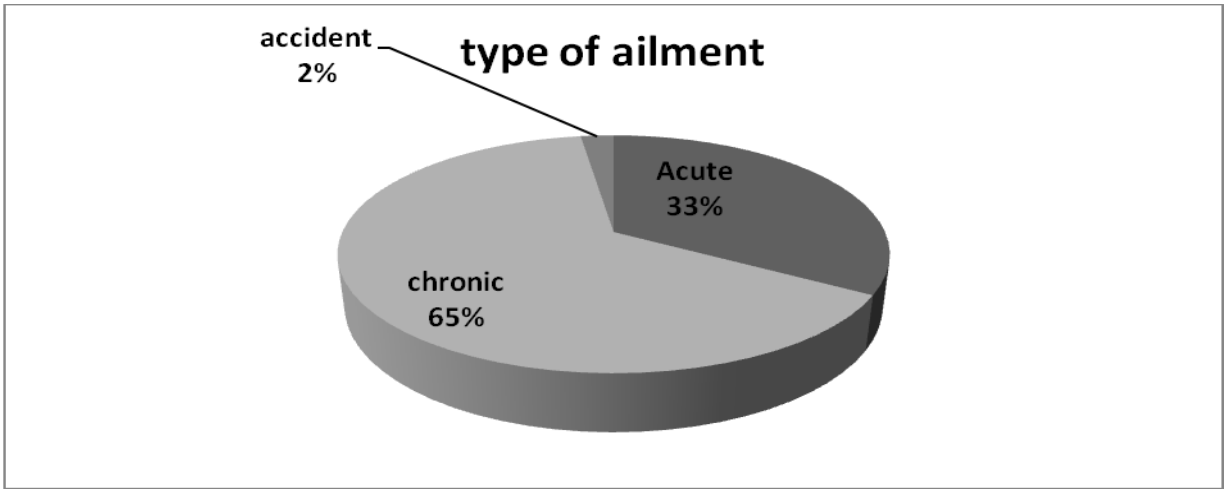


Fig 4: type of ailments

hypertension etc while one third patients got treatment for acute condition like typhoid, malaria and only 2.3% got admitted due to accidental condition

Change in behavior due to health insurance:

The data suggest that hospitalization increases significantly after the insurance, only 30 % of respondents or any member of their family got admitted in last two years before getting enrolled in this policy. In Haryana **702872** BPL families were enrolled under RSBY, While member of 51203 families got admitted in the hospital for any treatment during a year i.e 7.2%which is much higher than National Sample survey,2005 rate which is 2.3 percent in rural populations and 3.1 percent in urban populations, which indicate that the insurance coverage significantly affect the behavior of consumer as well as the behavior of the health provider.

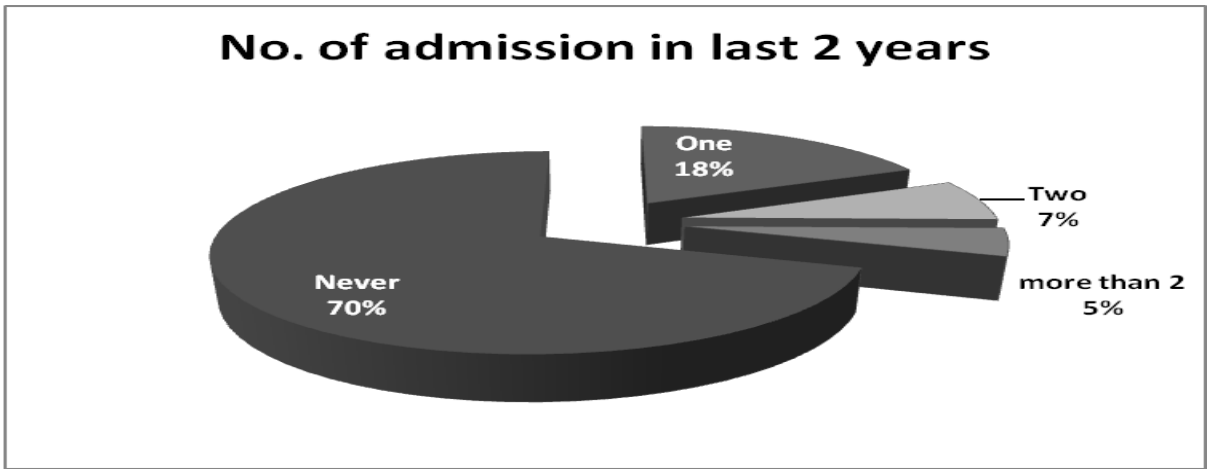


Fig 5: no. of hospital admission in last 2 years

There were 31 patients(36 %) ,who got admitted because it was more convenient and they need to pay from their own pocket, or while rest go admitted because either treating doctor or referring doctor advised them to get admitted.

Though moral hazard is quite prevalent among healthcare provider but even if we consider that all theses advice were genuine and those cases really needed to be admitted ,a large portion of beneficiaries showed changed behavior in presence of health insurance.

Out of these 31 cases, 15 were males (38%) while 16 were female (34%) ,When respondents were asked whether they would like to use government hospital facility after having health insurance cover, 40 % of female and 33% of male respondent said that they would like to go

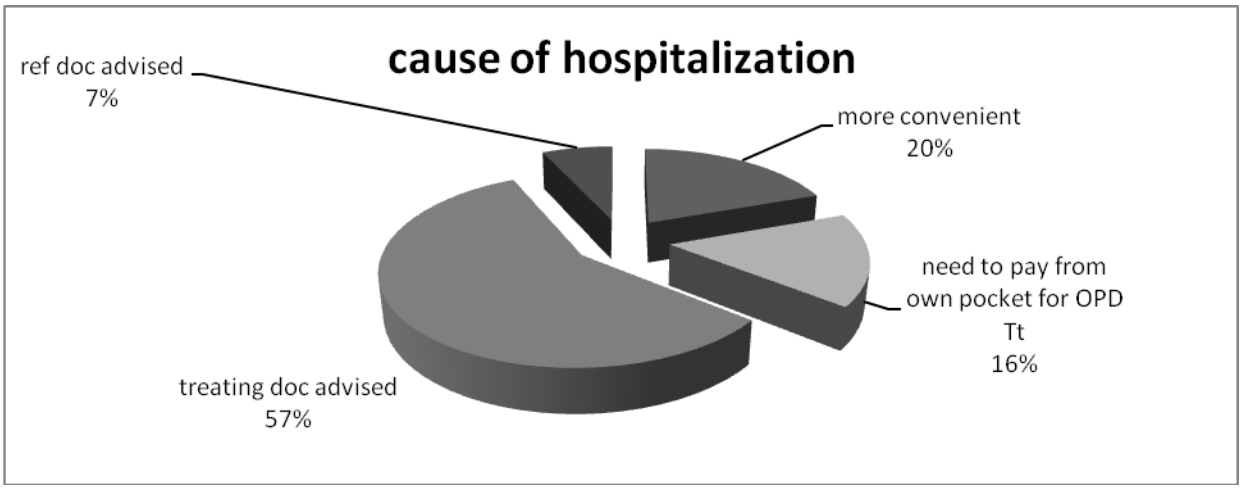


Figure 6: cause of hospitalization

to government facility even after having health insurance coverage while 70% 0f males and 53% of females were willing to go to government hospitals, in case they don't have any kind of health insurance, which means that health insurance changed 37 %(70-33) males and 13% (53-40) females behavior

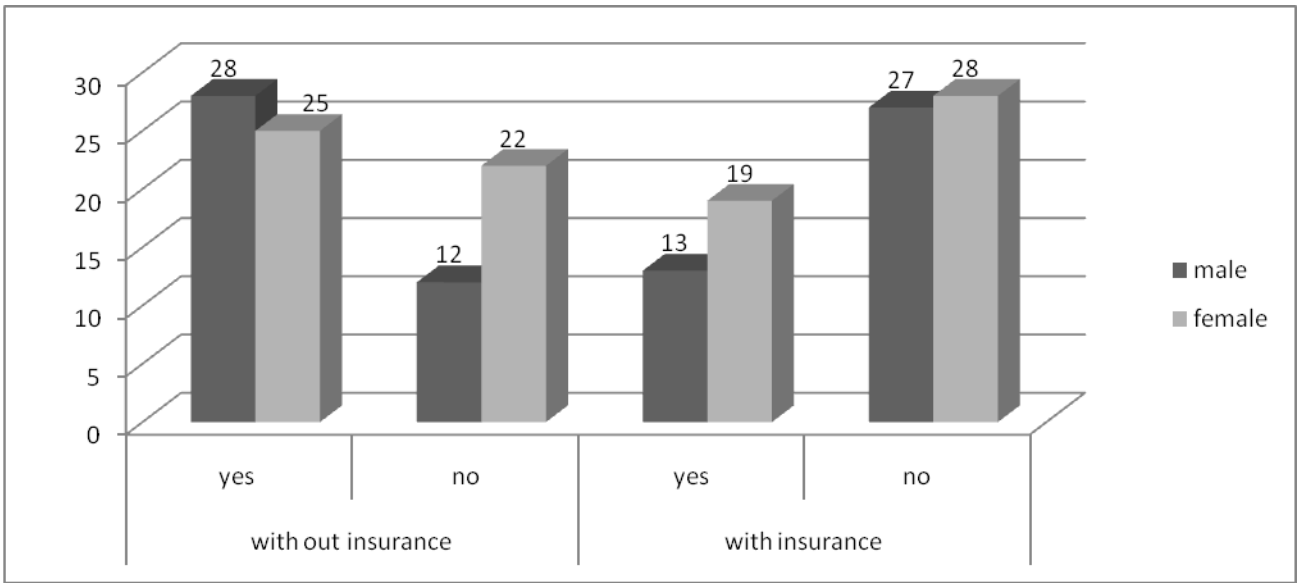


Fig 7:Willingness to use govt hospital

Out of 87 respondents, 17 patients got admitted and received treatment despite admitting that the underlying ailment was not causing much problem. During informal chats many patients admitted that they chose to undergo the treatment because they fear that insurance cover will not available in future and in case they need to undergo the same procedure in future, they have to pay from their own pocket.

Correlations

		treatmentwithoutcard	govthosp
treatmentwithoutcard	Pearson Correlation	1	.228(*)
	Sig. (2-tailed)	.	.034
	N	87	87
Govthosp	Pearson Correlation	.228(*)	1
	Sig. (2-tailed)	.034	.
	N	87	87

* Correlation is significant at the 0.05 level (2-tailed).

Data shows that there is correlation between pre and post insurance behavior but significance is not very high which means that though many people who were going to government hospital earlier for the treatment , would still like to go government hospital even after health insurance cover but there are many who would like to go to private hospital after health insurance, as they think that better care and more attention is provided by private hospitals than a government hospital. It proves that hypothesis 1 is right which was that health insurance change the behavior of beneficiaries .They start preferring private healthcare which they consider as better services, when they are covered by health insurance.

Effect of gender , sex and income on the behavior:

Similarly 36% of respondents in the age group 18-30 years,29 % in the age group of 31-40 yrs, 33% 0f 41-50 Yrs ,60% 0f 51-60 years and none above 60 years got admitted in the hospital without doctor's advice. Similar kind of pattern can be seen in relation to income level, 33% of patients below 10000 Rs ,13 % of patients having income 10001-20000 Rs /year, 44% of patients having annual income of Rs 20001-30000 per year got admitted without doctor's advice while 38% 0f patients with income of more than 30000 Rs/year were admitted just because either it was more convenient or Indoor treatment is free while OPD treatment is paid

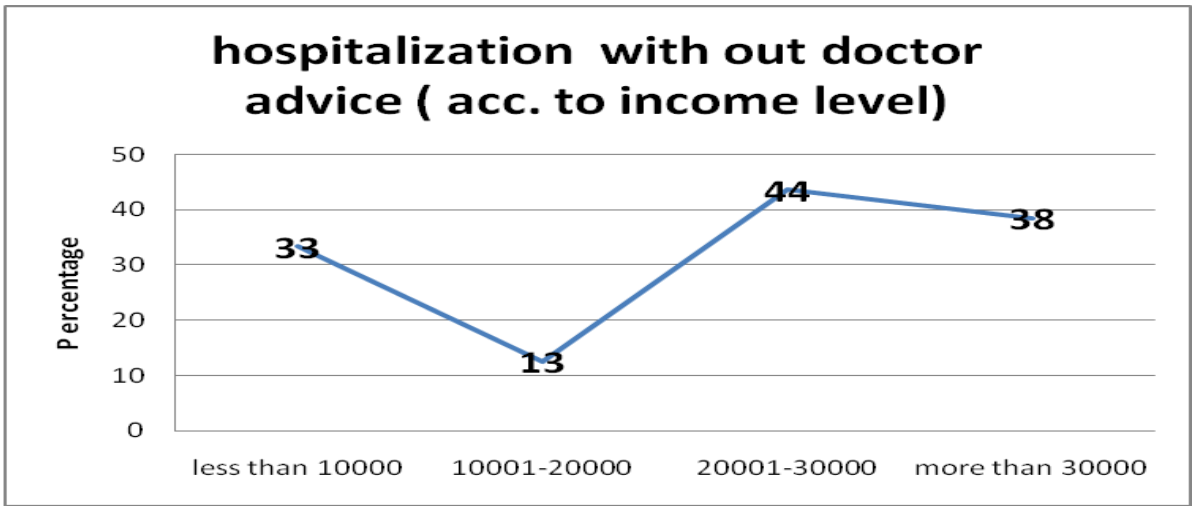


Fig 8: trend of hospitalization according to income level

Effect of health on consumer behavior was more visible in income level of 10001-20000 Rs and 20001-30000 Rs/annum , 49% of respondents of income level 20-30000/anuum were willing to use government facility when they are not covered by health insurance cover but when insurance cover is available only 18% respondents of this group were willing to use government facility in future. Similarly 81% of respondents with income of 10-20000/ annum were ready to use to government hospital without any insurance but only 38% of respondent wanted to use government facility, when they are covered by insurance.

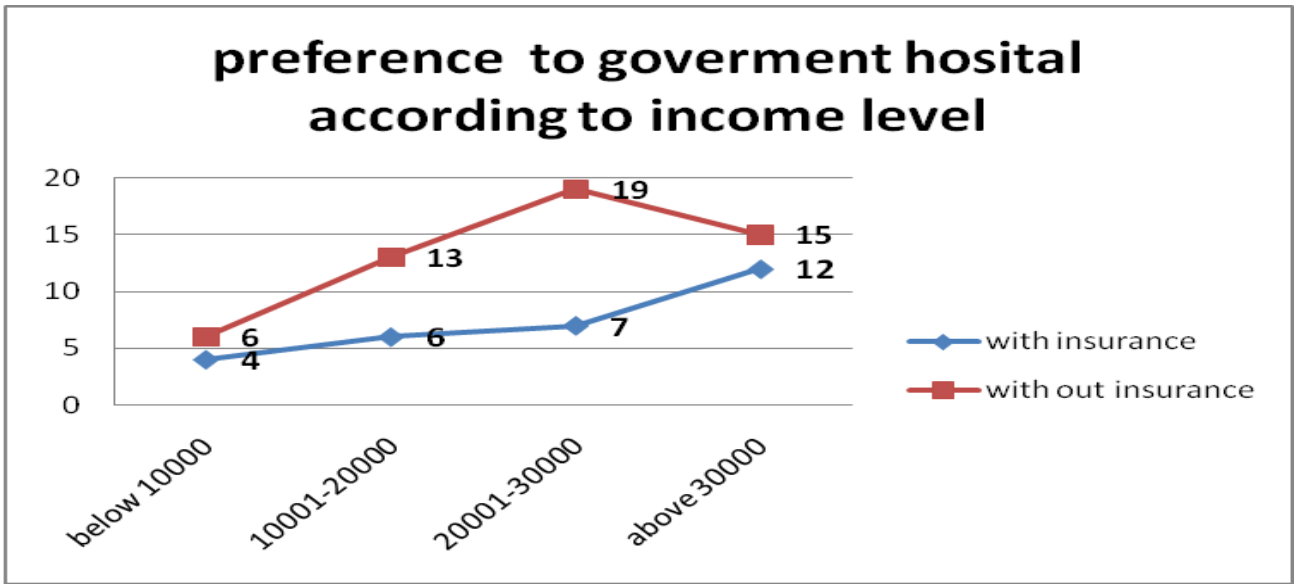


Fig 9: preference to goverment hospital

survey uncovered an overwhelming preference for private hospitals, physicians consultations), and pharmacies Out of 40(46%) respondents ,who received any kind of treatment before getting admitted to current hospital , 10(25%) received treatment from government institute while 17(42.5 %) got treatment from RMP (Rural Medical practitioners') and only 13(32.5%) took treatment from private hospitals. When they were asked about the place of treatment in case they did not have any insurance, only 22(25%) of respondents said that they would have chose private hospital, even if they have to pay from their own pocket, rest 75% either chose government hospitals or RMP. But insurance change the behavior of beneficiaries in such a great way that only 36.8% of respondents were ready to use to the facilities of government hospital, in case they have insurance. This figure is more important because already all treatment facilities are free for BPL families in government hospitals and now even general/civil hospital of each district of Haryana is empanelled for RSBY

All respondent were ready to go to the same hospital, in case need occurs in future and they have insurance cover but when insurance cover is not available ,only one fifth of respondents were willing to go to the same hospital. Which means 80 % of the respondents went to that particular hospital because they were covered by insurance and hospital was empanelled for the insurance scheme ,which also explain the cause of mad rush among hospital to get empanelled for the insurance scheme.

Correlations

		Same hospital	Admission reason
Gender	Pearson Correlation	-0.13	-0.16
	Sig. (2-tailed)	0.23	0.15
	N	87.00	87.00
Income	Pearson Correlation	-0.18	-0.13
	Sig. (2-tailed)	0.10	0.23
	N	87.00	87.00

age	Pearson Correlation	0.32	-0.04
	Sig. (2-tailed)	0.00	0.74
	N	87.00	87.00

There is negative correlation between gender and income with utilization of same hospital without insurance and reason of hospitalization without doctor's advice, Significance is also above .05, which means that is not significant. Though there is positive relationship between age and utilization of same hospital without insurance, which is also significant. But when the question of reason of admission comes in to the picture all age groups show similar kind of moral hazard. It proves that moral hazards are prevalent among all income, age and sex group which proves Hypothesis 2 is right which was that change in behavior is not related to gender, age or income level.

Willingness to pay extra for OPD facilties:

As preventive and diagnostic treatment are not covered under RSBY on OPD basis, so many times patients ignore the disease in early part of disease as they need to pay from their own pocket in case they undergo any preventive or diagnostic procedure without admitted .out of 40 respondent who did not receive any treatment earlier than current episode , 18(38.3%) foregone due to lack of money and 15(31.9%) said that the problem was not much and 13(27.7%) were not aware about the underlying condition at all. Forgoing early treatment and missing opportunity of diagnosing the disease in early condition ,result in to more serious condition requiring more intensive treatment resulting in to higher bill, which is neither beneficial for enrolled population nor for insurance companies.

This study suggest that a significant part of beneficiaries just get admitted in the hospital because they need to pay from their own pocket in case they take treatment from their own pocket and similarly opportunities of early diagnosis of the disease are missed also because OPD facilities are not covered in this policy

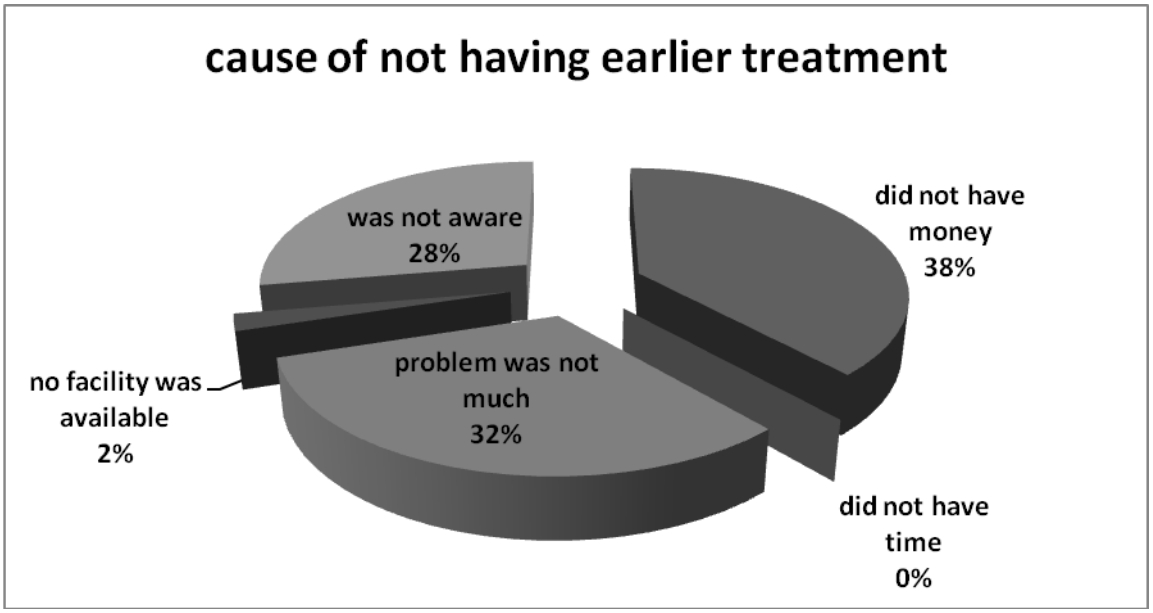


Fig 10: cause of not having treatment earlier

Most of the time insurance companies are reluctant for covering OPD facilities due to high administrative cost and high cost of controlling the frauds but some way can be found out to meet this cost .in this study 99% agreed to pay extra amount for this policy in case OPD facilities are covered in this scheme.41.46% of respondents were ready to pay more than 100 rupees from current 30 Rs for OPD facilities

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
OPD services	87	1.0115	.10721	.01149

People are willing to pay for OPD service in cases this facility is covered in this scheme .Hypothesis 3 & 4 also proved right which were : If preventive and promotive health services are covered in the insurance scheme, more and more people will like to go for these services leading to better health of general population. People would like to pay more for Smart card (health insurance),if this scheme also cover OPD, preventive and diagnostic services

Discussion;

Insurance is social institution that particularly invites moral contemplation about suffering, compassion and responsibility. In so doing, it enlarges the public conception of social responsibility. The basic premise of insurance is collective responsibility for harms that befall individuals because insurance pools people's saving to pay for individual's future losses(Jerrt 1996:17).The basic dictum about insurance is that it does not change the probability of an adverse event, it can only mitigate the financial consequences of the event. According to moral hazard argument, insurance actually increase the occurance of adverse events through its incentive to people who have insurance. When people are insured , they are less careful to avoid or prevent accidents , diseases, thefts and other losses and thus insurance indirectly increases the number of losses

In health care, these moral hazards mean patients do not hold themselves accountable for finding the quality of care they desire at a price that makes sense. Instead, patients often rush for more health care believing that more care is better care; or to specialists because this means more competent care; or to more tests because this translates to more comprehensive results; and finally to more drugs and more treatments because these mean a longer, happier life. And patients do so because they believe their care is "free." Due to the set up of the current "free" care healthcare system, patients are shielded from the actual costs of care, so they do not carefully consider these costs when assessing care. In a world with risk averse individuals and without moral hazard, full cover insurance (i.e. no deductibles) is a first best solution. Yet, in case of moral hazard, the first best solution is not feasible and introduction of mandatory deductibles can lead to a second best solution (c.f. Breyer et al.2004). Hence, finding out the price-elasticity of demand for health services is an important empirical task in order to design an optimal health insurance system. As health resources are scare, treatment of persons who are not in real need of treatment is done on the cost of people who don't have any insurance but in real need to treatment. This excess demand for (mostly trivial) health services could be contained via cost-sharing, e.g. deductibles or co-payments for doctor visits or hospital trips. However, the optimal amount of cost-sharing is a priori unclear. There have been several German studies in the past that analysed the impact of the insurance state on the number of doctor

visits or hospitalizations, eg. Pohlmeier and Ulrich (1995), Geil et al. (1997), and Riphahn et al., (2002).2 They compare the behaviour of individuals covered by private health insurance with those covered by public insurance. In the German health insurance system, the first group can choose between having a deductible or not whereas there are basically no deductibles for the second group. The studies provide some evidence that the probability of visiting a GP is higher for publicly insured, that is implicitly, for those without deductibles (Pohlmeier and Ulrich, 1995).

Moral hazard are not restricted to insured ,they are also related to health care provider.As 57.5% of insured got admitted because treating adviced so but many cases it was found that treating doctor adviced admission or any surgery ,when it can be avoided or at least post-phoned .E.g while interviewing a lady,30 yrs in a Kurukshetra ,who had undergone hysterectomy, it was found that this procedure could easily avoidable for at least few years ,it also came to notice that many times patients did not have full knowledge about the possible complications of the procedure and it was intentionally done because provider had this doubt in mind that patient may not agree for undergoing the particular procedure.
Study revealed 99 % respondent would not choose to go the same hospital, in case they are not insured or hospital is not empanelled for RSBY.As nearly 3 lakh persons are enrolled for this policy and in today's date no hospital want to loose this target audience, which also explain the cause why hospitals try to get empanelled in any possible way .There is great tendency of hospitals to claim the package of higher value. e.g in a year package of status asthmatics was blocked 2776 times compared to Acute exacerbation of COPD was claimed 2028 times. While COPD is much more prevalent than status asthmatics(kind of asthma which don't respond to standard treatment regime).Moral hazard are not only limited to RSBY they are related to each and every insurance .India's most popular community based insurance Karuna trust and Yashasvini also suffer from moral hazards, adverse selection and frauds.

Moral hazard in Karuna trust 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.

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

Where supply of health care services is scarcer and is distributed among many people who demand such services, its over-consumption is unlikely to assume any serious proportion. Therefore, ex post moral hazard problem in low income communities is unlikely pose any great difficult in design of health insurance. Furthermore, in a low-income society there is considerable scope for risk reduction which does not take place due to lack of health information such as basic hygiene sense, cause-effect relationships, and preventive measures. Even where such knowledge exists, or is provided, the difficulty is in motivating the people to follow such advice. The challenge instead is of encouraging preventive and promotive care among people, which is a precondition for making insurance viable and affordable. Most of the time insurance companies are reluctant for covering OPD facilities due to high administrative cost and high cost of controlling the frauds but some way can be found out to meet this cost .in this study 99% pay more than current 30 Rs for OPD facilities. Now it's a high time to control inefficiencies like moral hazard as much as possible and to find out a way to promote not only the curative part but also the preventive and promotive healthcare, it will not only help the insurance companies in reducing the claims in long run but will also help the community to raise the health standard .

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Annexure 1

QUESTIONAIRRE FOR PATIENTS

1. Name of the patient……..

2. Name of card holder……

3. Name of respondent…….....

4. Relationship with the patient

i)Self ii) parent

iii)sibling iv)spouse

v)Son /daughter vi) others

5. Age

i) 18-30 years

ii) 31-40 years

iii) 41-50 years

iv) 51-60 years

v) More than 60 year

6. **Sex** i)Male ii)female

7. Card no.(UHID)……..

8. House hold income

i) Less than 10000/year

ii) 10000-20000/year

iii) 20001-30000 /year

iv) More than 30000 /year

9. Hospital name…….

10 Location……..

11.Disease suffered

i) Acute

ii) Chronic

iii) accident

12. Treatment received

i) Medical ii) surgical

13. Did you know about the disease at the time of enrollment?

i)Yes ii)No

14. how many times any member of you family got admitted in last 2 years before getting this smart card

i)1 ii)2

iii)more than 2 iv)never

15. Does this disease was causing you much problem?

i)Yes ii)No

16. Have you taken any treatment for this problem earlier?

i)Yes ii)No

17. If no, why did you not take the treatment earlier?

I) did not have money ii) did not have time

Iii) problem was not much iv) facility was not available

18. If yes, where did you take the earlier treatment?

i) govt hospital/clinic ii)private hospital iii) RMP

19. Where have you undergone the treatment, in case you need to pay from your own pocket?

i) govt hospital/clinic ii)private hospital iii)RMP

20. In case, you need to pay from your own pocket, even then have you availed the services of same hospital?

I)Yes ii) No

21. Why did you get admit in the hospital?

I. Because it was more comfortable than coming back to hospital again and again in OPD

II. Because I need to pay from my own pocket in case I took treatment in OPD

III. Treating doctor advised to do so

IV. Referring doctor advised to do so

22. How many times did you use this smart for getting the treatment

i) 1

ii) 2

iii) 3

iv) More than 3 times

23. Would you like to pay some extra money for getting this smart card, if OPD services are covered in this scheme?

i)Yes ii)No

24. .In case your treatment can be done OPD basis and still it is free of cost, would you like to get admitted?

i)Yes ii)No

25. .How much would you like to pay for this scheme?

i) 30 rupees ii)30-50 rupees

iii)50-100 rupees iv)more than 100 rupees

26. Would you like to go to government hospital, after having this card?

i)Yes ii)No

27. In case , you need to use services of hospital again, would you like to use the same hospital services

i)Yes ii)No

28. In case no, the reason:

i. Not happy with services of hospital

ii. Better hospital are available nearer to residence

29. Are you happy with this scheme?

a. i)Yes ii)No

30. if no, reason

a. hospitals are not good

b. OPD services are not coverd

c. Hospital still ask for money

d. Other

reason……

……