# BARRIERS TO ENROLMENT IN MICRO HEALTH INSURANCE - AN EMPIRICAL STUDY OF SAMPOORNA SURAKSHA PROGRAMME IN KARNATAKA

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***Abstract :*** *Healthcare financing mechanisms in India are disappointingly skewed towards private out of pocket (OOP) expenditure that has resulted in iatrogenic poverty. Micro health insurance, which caters to the insurance needs of the bottom of the pyramid, is thus an innovation in health insurance market to tackle the impoverishing effects of huge medical bills and mitigate iatrogenic poverty. This study was conducted to ascertain the barriers to enrolment in Sampoorna Suraksha, a micro insurance programme initiated by SKDRDP (Sri Kshetra Dharmasthala Rural Development Project) in Karnataka. A descriptive study was conducted in Dakshina Kananda, Uttara Kannada, and Gadag Districts in Karnataka. Random sampling technique was used to select 355 non-insured members. A self-administered semi-structured questionnaire and focus group discussions were used to collect data from the non-insured members of SKDRDP. Our study confirmed that members did face different variety of barriers for membership enrollment. The incriminating factors responsible for such barriers this study was external to the scheme such as lack of money, cultural belief, intra household factors, and enrolment in other insurance schemes. Other factors found were related to insurance scheme design such as high premium, lack of clarity regarding scheme's rules, and problems with network hospitals. We provide preemptive measures to remove these barriers, and reiterate the role of microhealth insurance in mitigating Bharat's iatrogenic poverty.*

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

## Introduction

Globalization has been instrumental in pushing India in the economic growth trajectory by increasing the volume of transaction in terms of goods, services, ideas, technology, cultures and human capital. Achieving competitiveness in global market and accelerating economic development of any country will depend on the human development, as human capital is a clear determinant of growth and competitiveness. One aspect of human capital is good health that affects growth indirectly by influencing labour productivity, innovation and creativity. Moreover, fundamental objective of economic growth is to reduce poverty and tackle any problems that results in poverty. One of the problems in developing countries is the burden of illness and shorter life expectancy, especially for the poor. It has been recognized by the intellectuals that good health translates into higher income, higher inclusive economic growth and reduction in the growth rate of population. Human development index in terms of education, life expectancy, and standards of living should be improved by providing access to good health facilities in developing countries.

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

India's health financing mechanisms are to be blamed partly for this disheartening performance.

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Out of the available health financing options such as government budget, social insurance, private insurance, community-based insurance or micro health insurance, and patients paying out-of-pocket, the majority of the Indians resort to the last option that has resulted in iatrogenic poverty. With this background healthcare scenario in India, Micro health insurance has evolved to be a pivotal mechanism chosen by the poorer households to access and finance expensive health care. Student's Health Home was the earlier scheme started in 1952 in India. Since then, a number of schemes have been initiated in different parts of the country such as BAIF, DHAN, RAHA, SEWA, ACCORD, Karuna trust, Yeshaswini trust, VHS, and Navsarjan. In the Indian microfinance sector, the partner-agent model appears to be the dominant institutional arrangement for the delivery of micro-health insurance.

## Review of literature

### Micro health insurance in developing world

Research on the effectiveness of micro health insurance has concluded that it not only increases utilization but also reduces out of pocket expenses and catastrophic expenditure associated with ill health and removes financial barriers to access to health care (Jakab & Krishnan 2001; Schneider & Diop 2001). There are reports of reduction in out-of-pocket spending and increase in the utilization of health care services (Atim 1998; Desmet et al, 1999, Jütting & Tine, 2000; Schneider & Diop, 2001; Jakab & Krishnan, 2001; Aggrawal, 2010) and reduction in financial burden of seeking health care (Ekman, 2007). In addition to providing financial protection, MHI aims to include the poorest. MHI membership can reduce health expenditure more for the poor than rich (Jowett, 2002, Polonsky et al., 2008; Gumber 2001; Ranson, 2002; Zhang et al, 2010; Dror et al., 2005; Chankova et al, 2008 and Franco et al, 2008). However, effective design and management are critical to the success of health insurance schemes in achieving their objectives (Jakab & Krishnan, 2001; Ahmed et al., 2005; Atim 1999; Gumber & Kulkarni, 2000).

### Enrolment in Micro Health Insurance

According to Criel and Waelkens (2003), quality of care offered at the health centre is an important factor determining enrolment in a MHI scheme. Moreover, affordability of premium was considered as another factor that influences people's decision to join the scheme (Atim, 1998). Technical design factors such as unit of enrolment (family or individual) (Schneider & Diop, 2001), timing of collections of premium (annual or monthly) (Bennett et al., 1998), trust in the integrity and competence of management of the scheme, income of the family that determines affordability of premium (Jutting, 2001; Jakab et al., 2001; Msuya et al., 2004) also influence enrolment in a scheme. A study by Jutting et al. (2004) in Tanzania highlighted income, area of residence, and seasonality of income, family size, and quality of health care facility as the determinants of membership in a scheme. In addition, lack of information about the scheme also results in non-enrolment.

### Objectives of the study

1. To study and analyze the factors determining non-enrolment in Sampoorna Suraksha scheme
2. To construct socio-demographic profiles of non-subscribers of Sampoorna Suraksha scheme

### Research design

The cross sectional descriptive study was designed to collect the quantitative data through self-administered semi-structured questionnaires. In addition, exploratory study techniques namely focus group discussions/interviews was used for collection of the qualitative data. The study was conducted in three districts where SKDRDP is implemented. The non-insured members of Sampoorna Suraksha are the source of population for this study.

### Sampling Design

SKDRDP (Sri Kshetra Dharmasthala Rural Development Project) is a novel programme initiated in 1982 in Belthangady, Dakshina Kannada under the visionary leadership of Dharmadhikari Sri Veerendra Heggade of Sri Kshetra Dharmasthala to uplift the poor and transform poverty stricken households' better living through self employment. The programme covers Dakshina Kannada, Uttara Kannada, Udupi, Kodagu, Chikmagaluru, and Shimoga, Shimoga, Coorg, Dharwad, Gadag, Haveri, Tumkur and Belgaum districts covering 8000 villages, 41 towns and panchayaths. Total SHG groups working were 119000 and total numbers of families/ members covered were 1313000. The sample was drawn using multi-stage, clustering design with random selection procedures. The districts selected were Dakshina Kananda, Utatra Kannada and Gadag. Then proportionate to size sampling method (number of taluks selected depends on the total number of taluks in each district) was adopted to select 10 taluks from these districts, 97 circles (valayas), 84 divisions (karyakshetras) and 364 non insured self help group members of SKDRDP.

The number of non insured interviwed was from Bhatkal, Gadag, Honnavar, Karwar, Mangalore, Puttur, Shirhatti, Sirsi, Sullia and Kumta. For qualitative data collection, FGDs (five) were conducted in the same villages selected for quantitative data collection.

## Results

### Socio-economic and demographic Characteristics of the respondents

The quantitative data was collected from 364 respondents in 84 divisions of selected villages. 70 percent of the respondents were from the villages located at < 2Km (0.5-2. Km) from clinic/nursing home/ hospitals and 30 percent were from the villages located at >5km (2-12 Km). The data was collected from 364 non-subscribers that consisted of 22 percent lowest income class, 21 percent belonged to lower income, and 20.5 percent of upper income class.

The respondents were mainly women (86 percent), majority of them were married (73.4 percent) and one fifth of them were illiterate. 41.7 per cent respondents completed primary education and 25 percent respondents were secondary educated. A minority of 11.8 percent were degree holders and hardly 1 percent was professionally qualified. The major occupation of respondents was daily labour or beady-rolling (53.8 percent). However, 15.7 percent of them were engaged in skilled labour that paid better but only 3.3 percent were in formal sector. Majority of the household head were male (69.7 percent), of which 52.5 percent were between the ages of 45-70. The average size of household of majority of families was less than 5 (87.6 percent) and 82 percent of them owned dwelling house. Fifty four per cent of respondents lived in rural areas, and majority of them belonged to lower caste (56.3 percent) and Hindu religion (93.7 percent). The socio-economic background of the respondents is given in Table 1

Table 1: Socio-economic background of respondents

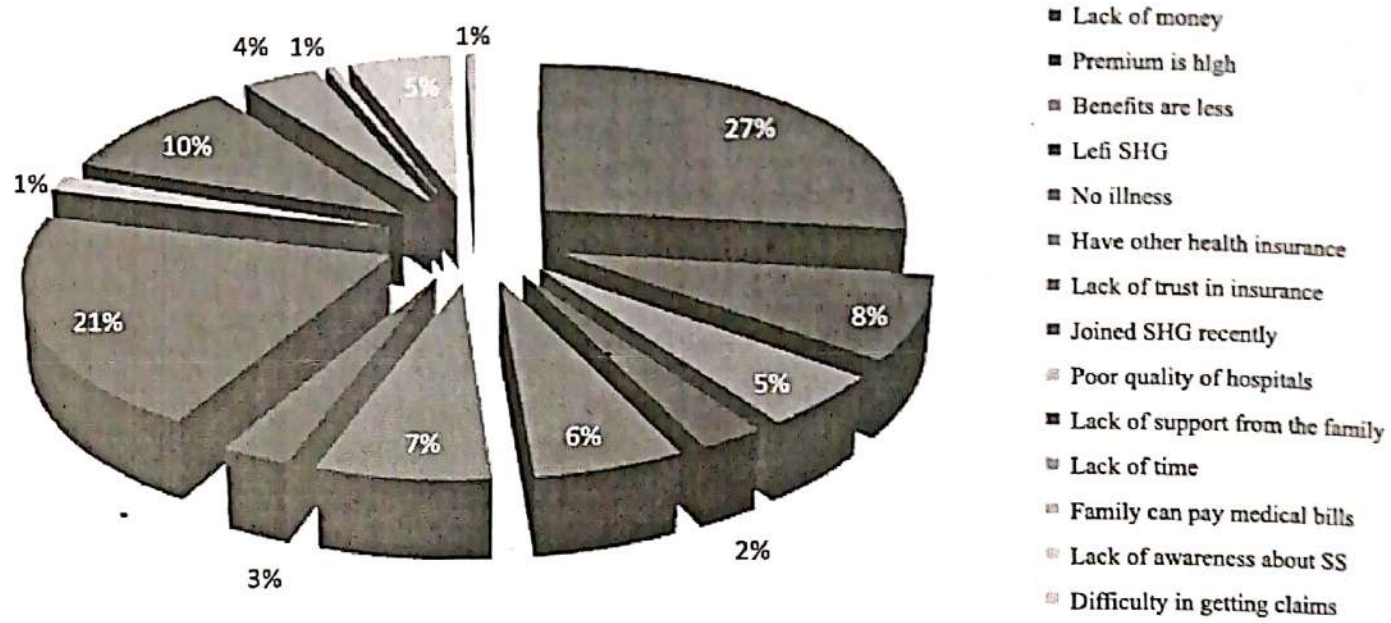
| | |
|---|---|
| Gender | |
| Percentage of male respondents | 14 |
| Marital Status | |
| Percentage of married respondents | 73.4 |
| Percentage of unmarried respondents | 13.7 |
| Education | |
| Percentage of respondents with no schooling | 21.4 |
| Percentage of respondents with primary education | 41.7 |
| Percentage of respondents with secondary education | 25 |
| Percentage of respondents with pre-university and degree | 11.8 |
| Percentage of respondents with vocational or professional degree | 0.9 |
| Family type and size | |
| Percentage of respondents with age <45years | 47.5 |
| Percentage of respondents' age between 45-85 years | 52.5 |
| Percentage of women headed households | 20.3 |
| Percentage of households with family size<5 | 87.6 |
| Percentage of households with family size >5 | 12.4 |
| Occupation | |
| Percentage of respondents involved in unskilled labour (beedi roller, daily labourer) | 53.8 |
| Percentage of respondents in skilled labour | 15.7 |
| Percentage respondents in self employment | 6.9 |
| Percentage respondents in formal sector employment | 3.3 |
| Income | |
| Percentage of families with income < 4500 | 22 |
| Percentage of families with income Rs. 4500- Rs.6000 | 20.6 |
| Percentage of families with income Rs.6000- Rs.8300 | 19.2 |
| Percentage of families with income Rs. 83000- Rs.12000 | 17.6 |
| Percentage of families with income> Rs. 12000 | 20.6 |
| Other characteristics | |
| Percentage of respondents with own housing | 82 |
| Percentage of respondents living in rural areas | 54.3 |
| Percentage of respondents of lower caste | 56.3 |
| Percentage of respondents of Hindu religion | 93.7 |

### Reasons for non-enrolment in Sampoorna Suraksha

Barriers to enrolment in Sampoorna Suraksha are both financial and non-financial. Lack of money, high premium, and ability to pay medical bills are the financial reasons for non-enrolment. Non-financial reasons can be categorized into scheme related factors, social factors and religious factors. Social factors included (i) no incidence of illness in the family in the last few years, (ii) enrolment in other health insurance scheme such as ESI (Employees' State Insurance) and Yashaswini, (iii) lack of time to fill the forms and pay premium, and (iv) lack of support from the family especially male members. Scheme related factors incriminated by the respondents as barriers included (i) lower benefits, (ii) poor quality of hospitals, (iii) withdrawal of membership from SHG, (iv) new member in SHG and

(v) difficulty in approval of the claims. Other cited barriers for non enrolment were ascribed to the prevailing religious and cultural factors such as belief that 'God will keep them healthy', misconceptions about health insurance (if one has health insurance, she would get sick) and the belief in alternative systems of medicine such as ayurveda and/or home medicine. The figure 1 shows the reasons for non-enrolment given by the respondents.

**Figure 1 : Reasons for non-enrolment in micro health insurance scheme**




Lack of money is one of the main reasons given by one third of respondents followed by joining SHG recently (20.6 percent), lack of support from family (9.6 percent), and high premium (8 percent). 18 respondents, leaving SHG by 9 respondents, cited lower benefits and no illness in the family was reason given by 21 respondents. Twenty-five respondents had other health insurance schemes, ten did not trust the insurance mechanism, five felt that hospitals in the network were of low quality and fourteen cited the lack of time as the reason for non-enrolment. Nineteen respondents were not aware of Sampoorna Suraksha and two respondents had the belief that claiming benefits under the scheme was difficult. Thus, main barriers identified were lack of money (economic factor), new SHG membership and high premium (scheme related factor), and lack of support from family (social factor).

### Reasons underlying qualitative findings

Focus group discussions (FGD) were carried out that lasted from 30 minute to one hour. The reason for non-enrolment was found out during these sessions in addition to the self-administered semi structured questionnaires. There are varied reasons identified for non-enrolment that includes religious and cultural reasons and socio-economic reasons.

The focus group interview with respondents revealed that lack of money was the single most important factor for non-enrolment. In FGD, this was explored further as there is credit facility provided by SKDRDP micro finance division to pay the premium. Many of them expressed their unawareness especially members in Gadag district. Majority of them did not enroll as they couldn't afford the premium and were unaware that they could borrow from MFI and pay back on a weekly basis e.g. 'No one told that we could take loan to pay the premium and pay back later'. Most of the respondents resort to home medicine for small ailments like fever, cough, abdominal pain, headache and such acute conditions. They usually go to outpatient departments for medicine or checkup that can't be claimed under Sampoorna Suraksha e.g. 'We don't get admitted until its absolutely necessary'; 'we usually go to our family doctor'; 'Lord Manjunatah will keep us healthy'. Religious commitment to Lord Manjunatha was another barrier for non-enrolment as they believed that he will keep their households healthy. In addition, belief in ayurvedic medicine was another barrier to enrolment. For even chronic conditions, most of the participants resorted to ayurvedic medicines from nearby clinics or family doctors. Another common misconception that prevailed in these regions was 'If we buy insurance, we will get illness', which demonstrates the need for psycho-education and awareness programmes for the benefits of micro health insurance schemes. The financial barriers for on enrolment were voiced

during the FGD as 'the prices have gone up; we can't eat three times a day; we have outstanding loans and payment of weekly installment of the loan itself is difficult'.

Another responsible factor elicited during the FGD for non-enrolment was related to domestic responsibilities. To quote some of the respondents from the FGD: 'Even if we have insurance, we have to forgo the days' work but we can't do that as we are poor; We have to cook, wash clothes and take care of elderly, so we take medicines from pharmacist or drink 'kashaya' (home medicine) if we fall sick.'

Another interesting finding of FGD shows the link between lack of money to enroll entire family and to quote: 'If I alone can register, I would have enrolled in Suraksha; but my entire family has to get registered; we have seven members and we can't pay that amount of premium'. Resource poor families can't afford to pay the huge premium amount for the entire family; thereby had opted out of the scheme. Usually insurance schemes follow the policy of household enrolment as a mechanism to control adverse selection that can choke the financial sustainability of the scheme. However, this strategy may not be ideal in micro health insurance that specifically targets poor people.

## Discussion

Our study has emphasized and reiterated that the enrolment in any micro health insurance will depend on socio-economic, religious and cultural factors. One of major factor is the unaffordable premium due to lack of money, which can be easily understood. The target population of the SKDRDP micro finance is the poor, of whom the majority was daily labours. The mean income of respondents was Rs. 8140 with standard deviation of Rs.5643. The minimum income was Rs.800 per month to maximum of Rs. 50000. From the 'frying pan to the fire' the recent inflation that has gone up by double digits, the stagnant daily wage, high consumption expenditure as reflected by our qualitative data, the resultant low savings has resulted in borrowings from the self-help group. Interest burden and principal payment will further wipe out any of the excess income after consumption. Thus, lack of money is one of the most crucial factors that led to non-enrolment. Furthermore, the premium that has increased in 2011-12 year has discouraged enrolment in the scheme. Religious and cultural beliefs strengthened by lack of awareness about the benefits of insurance have dissuaded the members of SKDRDP. Almost one fifth of respondents were illiterate and median educational qualification was 6th standard are clearly responsible factors for the unawareness and the lower trust in insurance mechanism especially Sampoorna Suraksha.

In the study, the lack of support from family, mainly objection by husband was another important reason given for non-enrolment. The social fabric of Karnataka is male dominated with women hardly taking any part in decision making process related to household issues such as determination of consumption expenditure, health care utilization and membership in any organization or programme. Many respondents felt that their empowerment was restricted by male members of family especially husband in case of married women. We found that their participation in micro finance institution activities (MFI) was restricted and enrolment in any scheme other than MFI was opposed, mainly due to lack of money and unproven benefits. In this regard, we reinforce the crucial need for psycho-educating the women in these families regarding the benefits of micro health insurance, at the same time, influencing the men workforce to get approval to support other non-male family members. From our FGD, we advocate that the field staff of SKDRDP should play a pivotal role by sensitizing the head of the families on the advantages of insurance.

During the FGD, it was evident that many women could not enroll in Sampoorna Suraksha. The reasons incriminated were (i) most of the women in SHGs were the sole earners in the family, (ii) lack of time for enrolment before the due date, (iii) many of them couldn't make the premium payments on time. We found that the recently started SHGs couldn't enroll, as the Sampoorna Suraksha membership was kept open only during February- March.

The study revealed the popular misconception of 'Good health denotes freedom from diseases which doesn't entail the need for micro health insurance'. This shows the lack of knowledge about the benefits and advantages of micro health insurance. If this misconception is not promptly addressed in the regions, we feel that the scheme may be under the threat of financial sustainability due to adverse selection. A successful health insurance scheme should have both healthy and sick such that cross subsidization and transfer of risk from sick to healthy, and from rich to poor. This stresses the lack of understanding of insurance mechanism among members of SKDRDP. Another finding that may be detrimental to the scheme sustainability is that households with high income (17 percent in Q5) stay out of insurance scheme that is meant to benefit the poor, thereby limiting the income and risk pooling effect of insurance mechanism. The households opined that they can afford any costly health

treatment if illness strikes the family but didn't want to be the member of Sampoorna Suraksha.

Our study demands an urgent need to sensitize the members about the benefits of the scheme, excluded diseases and procedure to claim the benefits. Financial barriers to enrolment can be tackled by educating the members about the loan facility to pay the premium and may be cross subsidizing by charging a little higher premium to high income families and lowering the premium for lower income families. We propose that Public private partnership (PPP) through government involvement in the form of grants will be able to foster financial sustainability of the Sampoorna Suraksha scheme.

## Conclusion

In conclusion, we reiterate micro health insurance, as an innovative health care financing mechanism in mitigating Bharat's iatrogenic poverty, has to be supported by the policymakers. Adequate preemptive measures must be evolved to remove barriers to non-enrolment in micro health insurance. "Inclusive growth through health for all" should be the new mantra of the policymakers in India to realize the hidden human resource potential and transform the country into a developed India. Achieving the health system goals require united efforts from all sections of the society. Corporate philanthropy can be channelized into health sector to ensure equitable access to quality health care especially to poorer section of society. Mere financial inclusion will not lead to equitable economic growth.

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