Highlights of Community Health Insurance and Family Health Protection (FHP) Plans for India.

I. Population Coverage:

We recommend a community health insurance scheme targeting all residents of an area with a premium structure that incorporates graded state subsidy for various low income families. The health insurance coverage will be available to a community, if it guarantees that at least 75% of its constituent families will purchase the policy.

II. The benefit package and entitlement to benefits:

Our preferred policy includes comprehensive ambulatory and primary health care. The first component Primary Ambulatory care consists of Out Patient services and First Aid, Immunization and Access to Public Health Programs, Dental and Eye care, Lab services, Drugs and Referral Services. The Hospital Access component would provide facilitation and advocacy services to access Govt. Hospitals and Health Care Institutions (HCI), Supply / cost reimbursement of medicines and materials and Emergency hospitalization treatment There will be a financial cap of Rs 30000 / annum/ family on the cumulative value of medicines, materials and reimbursement.

III. Organisation of health services:

These policies are designed to work through existing health care infrastructure and eventually stimulate growth of required infrastructure. The above component services covered by these policies will be delivered through; (a) the clinics, (c) public hospitals, (d) private nonprofit hospitals, (e) private for-profit hospitals (f) participating pharmacies, and (g) diagnostic facilities. Clinics set up by practitioners of Indian Systems of Medicine can also participate. Primary Health Centers (PHCs) can participate but will have to compete with private not for profit and for profit clinics.

A participating clinic must satisfy the required quality of service standard. The quality of service standards will be as prescribed by the concerned mutual health organisation and may be based on a minimum quality of service standard prescribed by the concerned state public health authority.

IV. Provider payment mechanisms:

A combination of provider payment mechanisms is recommended. Primary Ambulatory Care, Facilitation and advocacy services to access Govt. Hospitals and HCIs and access to major medical relief from public or charitable sources is through Capitation fee to participating clinic nominated by the policy holder. Supply / cost reimbursement of medicines and materials is by Price per item mechanism and emergency hospitalization treatment is by Case payment based on a schedule of diagnoses.

The ambulatory primary care component should be provided through a clinic with a subsisting participation agreement. Arrangement for provision of the hospital access, access to catastrophic illness relief funds, and major medical expenses access services will vary. The service organisation may chose to directly provide all of these services and subcontract parts of it. We anticipate that, in some areas, there may be a scope to enlist support of local social service organisations, or social workers.

V. Cost estimation and cost control

Major determinants of health insurance costs are; (a) demand for services by the covered population, (b) cost of production or price of medical care, (c) transaction costs of the insurance. The following premium structure is recommended.

Family situation	Rate / Annum
Basic enrollment premium for individual or family with upto 3 members	600
Additional premium for family members exceeding three.	220

Total premium for a three member household works out to Rs. 660 / annum. In practice, the insured families will consist of one, two and three member families. Our conjecture is that the actuarial average may work out to about Rs. 600 / family / annum. More accurate actuarial average can be computed only after some experience about the composition of covered families is available. A family will be enrolled only if premium is paid for all members of the household in which the family lives. Thus if two or more families share live in a single household, both families have to enroll.

We propose that these community health insurance schemes be operated through mutual health insurance firms. The insurance function played by nonprofit mutual health insurance firms, coupled with the capitation based provider payment system, it is anticipated,

that it will keep administrative costs down. Accordingly we propose that the administrative cost of mutual health insurance plans be limited to 10% of premium income.

VI. Financing community health insurance:

We propose a system premium subsidy graded according to the income. For the poor families a range from 75 to 90% subsidy, for Low Income Families 50%, for Middle Income Families 20% and for High Income Families no subsidy is recommended. The actual subsidy will depend on situation in each state, their finances and decisions by respective state governments.