

Paper 25

MICRO HEALTH INSURANCE FOR THE POOR- A CASE STUDY OF SAMPOORNA SURAKSHA SCHEME IN MANGALURU CITY

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Abstract:

The greatest hurdle for poor families trying to be independent is the sudden incidence of serious illness requiring hospitalization. Today hospitalization expenses are so high which will drain the savings and push the poor to the vicious cycle of debt. Apart from medical expenses, other non medical expenses like, births and deaths also put them under severe financial crisis. Health is a right of everyone. The private companies offer different kinds of health insurance schemes with a premium which can't be afford by the poor sections of the society. Therefore micro insurance is one such scheme which will be exclusively helpful for the under privileged people in the country. The present case study focuses on the usage of the micro health insurance by the holders of the scheme. Study throws some light on the problems faced by the facilitators of micro insurance scheme. Data has been analysed by taking the beneficiaries of micro health insurance scheme sampoorna suraksha in Mangaluru city, of DK district. The findings of the study reveal that there is a maximum use of insurance scheme by the holders of the same. Micro Insurance schemes are functional mainly because of the NGOs. There is a need to support these NGOs to run these schemes in the long run in the most successful way. This can be made possible by providing them with financial assistance and help. But there can be some changes or developments done by government facilitate the continuity of the scheme.

Keywords : Sampoorna Suraksha, NGO, Health Insurance, Rural Poor, Women.

1. Introduction:

In India people in the below poverty line face a major financial crisis associated with health. Every serious illness, every accident and every natural disaster threatens the very existence of poor people and usually leads to deeper poverty in the rural India. The poor and rural population in India is still in worse economic conditions as compared to the urban population. They are exposed to various risks and their insurance requirements are not fulfilled easily as such. The development of a nation must consider and include all sections of the population of the nation.

As the major population of our country resides in villages and deprived of many facilities to grow and prosper, it is very necessary to take actions through various plans and policies to uplift them.

Poverty is not just a state of deprivation it is also backed by latent vulnerability. Micro insurance therefore, provides greater economic and psychological security to the poor as it

reduces exposure to multiple risks and cushions the impact of a disaster. There is an overwhelming demand for social protection among the poor. Micro insurance in conjunction with micro

Savings and micro credit could, therefore, go a long way in keeping this segment away from the poverty trap and would truly be an integral component of financial inclusion²

2. Micro Insurance in India:

Micro insurance business is usually done through intermediaries like non-government organizations, self-help groups or through microfinance institutions. The Government of India has taken initiatives through the Insurance Regulatory and Development Authority (IRDA) under the IRDA Micro-Insurance Regulations, 2015. Traditional insurance companies do not like to approach this segment of society because of many reasons. Thus, Micro insurance is the solution for such people. The first and foremost priority of any Government is to eradicate the poverty of its population. In fact, in this move to reduce the poverty apart from the Government even the NGOs, Society and the corporate world are also expected to contribute in this move. In one-way poverty can be the best indicator showing the progress of any nation.

3. Sampoorna Suraksha as a Micro Health Insurance

Sampoorna Suraksha Group Health Insurance Programme is a unique and a great initiative of SKDRDP a large sized NGO based out of Dharmasthala, the abode of Lord Manjunatha Swamy and managed by Dr. D. Veerendra Heggade. “Sampoorna Suraksha” (total security) is a welfare scheme to give financial assistance to the poor people in their days of severe health problems necessitating hospitalization. In this programme members contribute to bring security to their insecure life during severe ailment/accident. The entire programme is designed on the basis of mutual help. Interested members of SKDRDP participate in this programme by contributing an annual subscription.

SKDRDP has tied up with the insurance companies for providing coverage of hospitalization expenses for the poor called Sampoorna Suraksha. This program collects pre-designated premium to provide hospitalization coverage, meet maternity expenses, death compensation, calamity compensation, domiciliary treatment and accidental coverage. Annual subscription is based on the premium quoted by insurance company for providing health cover.

In order to give opportunities to the housewives and unemployed young women in rural areas who have time and inclination to do social work, SKDRDP has developed a new cadre called the Sevaprathinidhi, who work in their spare time and support the SHG movement in the village. Most sevaprathinidhis are women and this has positively influenced women men ratio in the organisation.

Sampoorna Suraksha is a section 25 company and a subsidiary of SKDRDP. Apart from building the future for poor people, it's necessary to keep the present in good strength. Health Insurance is one such thing which builds strong foundation for the present state of affairs. In order to build a strong foundation Sampoorna Suraksha was established to give excellent medical facilities to poor people.

4. Literature review:

Pejawar, A. (2013)¹ explains that there is a synergy between banking industry and insurance industry. Using this synergy rural population can be provided with financial solutions. Its

possible with one stop shopping only. In rural areas the PSU banks and RRBs are the successful vehicles for the distribution of micro insurance.

Priyanka, P. (2013)² has explained the factors which hinders the performance of micro insurance in India. She feels under utilisation of distribution channels and mismatch of needs and the standard products also sometimes become the main problemes of micro insurance. For the insclusive growth its important for the insurance companies to reduce the costs which may be both managerial and financial. There is a lack of training among the agents of insurance companies. Insurance companies must invest in the training and development of these experts.

Pranav Prashad, J. L. (2014)³ explains the benefits of using mobile phones in the rural market for the promotion of micro insurance. It should increase the efficiency of transactions across the entire value chain, improving processes such as enrolment, premium collection, and claims settlement. Author presents several challenges that insurers and mobile network operators are likely to face as they venture into this space. The lack of distribution infrastructure, such as roads and payment platforms, has been a major barrier to the spread of micro insurance, with a significant amount of time, effort, and money required to collect and transfer information and administer products manually.

P K Rath, G. E. (2014)⁴ has given some suggestions to the financial institutions and insurers to approach the informal market. He feels it can be done by following any of these two ways they are either informalize the institutional set ups or tie up with another institution which is informal.

A relook at micro insurance, in essence, would call for a relook at insurance itself – which is about putting the power of mutuality to work, empowering people and communities towards managing lives and risks. Commercial insurers have a role to play as technical support providers and in building capacity and spread through reinsurance. Government may need to play a role in supplementing the community's pool and serving as an insurer of last resort in the event of ruin.

(Balakrishnan, 2015)⁵ has undertaken a study in Nagapattinam district of Tamil Nadu with the aim of evaluating micro insurance delivery mechanism. He has taken Dhan foundation and Avvai two institutions providing the scheme. It found out that the institutions increase the sale of policies and emphasizing renewals. The reasons are the institutions are facing the problems of either declining ratio of renewals to the number of potential renewals or decrease in the sale of policies. But organizations are successfully settling the claims. Challenges are educating the customers by creating the awareness of micro insurance.

Bhattacharya, A. (2016)⁶ feels that Micro insurance is the most underdeveloped part of microfinance. The drawback for the spread of micro insurance are low enthusiasm towards low income, lack of promotions, less benefits, conditions like exclusions for pre existing diseases.

The author feels that the root of success of these MIs is the insurance company's ability to accept the small payments of the beneficiaries. Sustainability of micro insurance schemes can be possible with good design and quality.

(Neelamegam, 2018)⁷ opines that the outreach of micro insurance product is severely hampered by the uncertain and low income of the poor. This paper brings to light the preference of low income customers for micro insurance policies in Kollam district, Kerala. Micro insurance company/ agent is required to know the preferences of prospective buyers of the policy. The analysis has brought to light that the preference for holding micro insurance

policy varies significantly in respect of area of residence, age, gender, educational level and annual income of policyholders.

5. Conceptual framework of Micro Insurance

There is no unanimously accepted definition of micro insurance inspite of vast usage across the stakeholders. The concept of micro insurance has also contributed by the concept of micro finance. There are different models of micro insurance given by different authors in their studies. Partner- agent *model* is one such model where insurer takes the help of MFIs for the distribution of micro insurance schemes. *Full service model* makes the scheme itself is in charge of design and delivery of products. There is advantage of full control. But there is higher risk on the provider of the same. The earlier Yeshaswini scheme is the example for this scheme.

Provider Driven Model is a model the healthcare provider is the micro insurance scheme, and similar to the full-service model, is responsible for all operations, delivery, design, and service.

Manipal health card is the example.

6. Meaning as per IRDA act 2015;

“Micro insurance policy means an insurance policy sold under a plan which has been specifically approved by the authority as micro insurance product Sec2(g)IRDA act.”

2(h) of the act defines Micro Insurance product as “any general micro insurance product or life insurance product or health insurance product , proposal form and all marketing materials in respect thereof.”

The below table shows the maximum coverage available for the micro non life insurance scheme

Type of Cover	Maximum Amount of Cover	Term of Cover Min.	Term of Cover Max.	Minimum Age at entry	Maximum age at entry
Dwelling and contents, or livestock or tools or implements or other names assets or crop insurance—against all perils	Rs.1,00,000 Per Asset/ Cover	1 year	1 year	N.A	N.A
Health Insurance Contract (Individual)	Rs. 1,00,000	1 year	1 year	Product specific	Product specific
Health Insurance Contract (Family/Group)	Rs 2,50,000	1 year	1 year	Product specific	Product specific
Personal Accident (Individual/Family/Group)	Rs. 1,00,000	1 year	1 year	Product specific	Product specific

7. Research Design:

The study is done by taking both primary and secondary data. Primary data has been collected from the beneficiaries of Sampoorna Suraksha in the past 3 years. Again data has been collected from the NGO by conducting an interview with the director of Sampoorna Suraksha. Secondary data has been collected from the research articles taken from the journals.

8. Sample size:

The Sample size of beneficiaries in Mangaluru is based on the number of members who claimed cashless benefits in the past 3 years. The total members who claimed cashless benefits in the last three years is 5153. So sample is taken at 1% of the 5153, which is 51.53 approximately 50 respondents.

9. Objectives of the study

1. To understand some economic status of beneficiaries of the scheme.
2. To find out the usage of the sampoorana suraksha scheme by the members in Mangaluru over the period of 3 years.
3. To understand the challenges faced by the NGO and the strategies to overcome the same

10. Analysis and Interpretation of data:

Tables showing the socio economic conditions of the beneficiaries of Micro health Insurance scheme.

1. Age and Poverty line of the users.

Age	Frequency	%	Poverty line	frequency	%
25 - 40	23	46	APL	9	18
41- 55	19	38	BPL	41	82
56 and above	8	16	Total	50	100
Total	50	100			

(primary data)

Interpretation; The above table shows that most of the the respondents are of 40yrs age group. There are 19 respondents coming within 41 to 55 age group which is 38%. There are a few respondents who are 56 and above, which is 16%. The above table also shows the standard of living of respondents through poverty line. 82% of the respondents come under below poverty line category. Only 18% of the respondents are coming under APL category.

2. Table showing employment status and annual income of the respondents.

Employment status	Frequency	Percentage
House Wife	17	34.0
Beedi Rolling	15	30.0
Coolie	4	8.0
Tailoring	1	2.0
Agriculture	1	2.0
Private Company	2	4.0
Others household work	3	6.0
Panchayath member	1	2.0
Cashew factory	6	12.0
Total	50	100.0

(primary data)

Interpretation: A 30% of members depend on beedi rolling. At the same time an equal percentage of respondents do not work. Next higher number of respondents work for cashew

factory, which is 12%. A small number of respondents depend on other jobs like coolie, working as maids, tailoring, agriculture.

3. Table showing the annual income of the family of respondents

Annual Income of the family	Frequency	Percentage
Less than 25000	2	4.0
25000-50000	17	34.0
50001-75000	9	18.0
75001-100000	5	10.0
more than 100000	17	34.0
Total	50	100.0

(primary data)

Interpretation: The above table shows that 34% of the respondents have got a family income which is ranging from 25000 to 50000. An equal number of respondents have family income which exceeds 1,00,000 rupees a year. A small number of respondents that's 4% have a family income less than rupees 25,000.

4. Table showing the source of income to pay the premium

Source Of Income	frequency	Percentage
own income	20	40.0
husbands income	19	38.0
Children's income	7	14.0
family income	4	8.0
Total	50	100.0

(primary data)

Interpretation: 40 percent of the respondents pay premium out of their own income. But an almost equal number of respondents depend on their husbands income to pay their premium, which is 38%. A very few respondents depend on their children and family to pay the premium.

5. Table showing the number of times the benefits has been received by the members in the last three years.

Time	Frequency	Percent
once	21	75
twice	6	21
four times	1	4
Total	28	100.0

(primary data)

Interpretation: the above table shows the total number of members who received the claim for themselves. Which is 78 members out of 50. Out of which 75% of members have recieved the claim only once. 21% of the respondents have recieved the claim twice and only 4% of the members have received the claim for four times in the last three years.

6. Table showing different types of deseases the insurance is used for by the respondent for their own purposes.

Disease Family	Frequency	Percentage
Medical conditions (primary+secondary+ Acute)	15	54
Accidental injury	1	4
Surgeries minor	6	21
Major surgeries	4	14
ENT	-	-
Maternity	2	7
	28	100

(primary data)

Interpretation: The above table indicates that 54% of the respondents have utilised the scheme for treatment of medical conditions. Which includes primary, secondary, acute and chronic. 21% of them have utilised for minor surgeries. 14% of them have utilised the scheme for some major surgeries. Only 7% of them have taken the benefit for delivery. 4% of them have utilised the scheme under accidental surgeries.

8. Table Showing out of pocket expense incurred by beneficiaries.

Out of pocket	Frequency	Percent
nil	9	32
less than 5000	10	36
5001-10000	5	18
10001-15000	2	7
15001-20000	2	7
Total	28	100

(primary data)

Interpretation: The above table indicates that out of the total number of respondents who utilised the services for self only 9 of them got the full amount claimed which is 32%. There are 10 respondents who incurred expense less than 5000 which is 36%. 18% of them incurred expenses within 10000. Only 7% of the respondents have incurred OOP between the range of 10000 and 20000.

9. Table showing the usage of insurance scheme for different diseases by the family members of the respondents

Disease Family	Frequency	Percentage
Medical conditions (primary+secondary+ Acute)	18	53
Accidental injury	2	6
Surgeries minor	7	21
Major surgeries	2	6
ENT	2	6
Maternity	3	8
	34	100.0%

(primary data)

Interpretation:

The above table indicates 34 respondents used the scheme for their family. Out of which 53% of respondents who have used the insurance scheme for the purposes of medical conditions such as primary, secondary, acute sickness which requires only a medical treatment. 21% of the respondents have taken the benefits of insurance scheme for the purpose of minor surgeries. 6% of them have used the scheme for major surgeries, accidental treatments and ENT. 8% of the respondents have used the scheme for the purpose of maternity of their family members.

10. Table showing bill amount exceeding the claim amount in case of family use.

Amount in excess of the claim	Frequency	Percent
nil	19	56
less than 5000	7	20
5001-10000	3	9
10001-15000	1	3
15001-20000	1	3
25001-30000	2	6
more than 50000	1	3
Total	34	100

(primary data)

Interpretation:

The above table indicates that 56% of the respondents said that they did not pay any additional in excess of the claim. 20% of the respondents have paid the extra charges which is less than 5000 rupees. 9% of the respondents incurred the amount between 5000 and 10000. There is 6% of the respondents who paid the amount which is within 25000 and 30000. 3% of them have paid between the range 10000 to 20000. 6% And again 3% of them paid more than 50000.

Problems faced by the NGO :

1. To give awareness among the rural poor. As these types of schemes are offered to the poor section of the society who are generally less educated and from rural background. Giving them awareness about the scheme itself is a tedious job for the NGOs. This requires additional effort on the part of NGOs to appoint additional staff to go to the field and render services to the rural people at their doorsteps.
2. To make sure that the scheme sustains in the long run. As the premiums are increasing because of increase in the cost of health expenses, it's difficult to survive in the long run. This is because the beneficiaries are in low income category.
3. There is no additional income from micro insurance schemes. Rather there is an additional cost of overhead on the NGOs. It's social service offered by the NGO, SKDRDP which no other institution must have done. Because this institution is one of the largest and oldest of some other NGOs in Karnataka, it's possible for the institution to run the scheme successfully for many years.

4. There is no additional funding by the government to run this scheme in the long run. NGOs do not get any monetary assistance from the central or state government to pay for their additional cost of overheads.
5. Difficulty in settling grievances. Some times the NGO finds it very difficult to convince and console the members who come with some complaints. Its because the rural illeterates are not able to understand the technicalities of insurance.

Findings of the study

1. The study reveals that most of the respondents fall within the age group of 40 ears and many of them come under BPL category.
2. Most of the respondents are financially self dependent. We can see that out of 50 respondents only 17 members, which is 34% of them do not go for any kind of job. Remaining 33 respondents or 66% of them are into something or the other. But mostly coolie work.
3. Most of the members annual income comes within the range of 25000 to 50000, which is 34%. There is another 34% of them are having a family annual income which is more than rupees one lakh. It's a very good sign that a very few respondents have an annual income of less than 25000, which is 4%.
4. There is a highest percentage of respondents, which is 40% paying the insurance premium by themselves. They do not depend on others income to pay for the premium. There is a good number of respondents depend on their husbands income to pay the premium of the insurance which is at 38%. Then the samll number of respondents depend on either their children's oncome or on the income of any other family member.
5. In last three years 75% of the respondents have availed the benefits of insurance only once in the last three years. Means others might have used the scheme for family members. 21% of them have utilized the scheme twice and only one respondent has used the scheme for four times.
6. The study reveals that, most of the respondents have used insurance claim for the medical treatment, which is at 54%. This means the respondents have used the services either for primary or secondary or acute or chronic health condition which required only a medical treatment. These sicknesses include cold, fever, asthma, pneumonia and some other ailments which requires only a treatment and not the surgery. 21% of them have used the benefits for minor surgeries and 14% of them have used the benefits for major surgeries. 7% of them have used the services for materity purposes.
7. The study reveals that out of tototal number of 28 respondents who utilised the services for self there 32% percentage of respondents who did not get to pay any amount extra out of pocket. 36% of them incurred OOPE, which is very small amount of less than 5000. 18% of them incurred the additional expenses within the range of 5000 and 10000. A small number of respondents had incurred amount which is within 10000 to 20000 out of pocket expense.
8. The family members of the respondents have also availed the benefits of health insurance many times for the purposes of treatment of medical conditions, which is 53% of the respondents. About 21% of the members have utilised the services for minor surgeries, 6% of the respondents have utilised the benefits for major surgeries. Around 8% of them have utilised the servicess for the purpose of maternity.
9. The study reveals that, out of the total number of 34 respondents who availed the benefits for their family members, there is 56% of the members, did not pay any excess amount from their pocket. 20% of them have paid an amount which is less than 5000. 9% of them paid within the range of 5000 and 10000. 6% of them have incurred extra expense within the

range of 25000 to 30000. There is only one respondent who had paid an amount exceeding 50000 rupees.

Suggestions and strategies to overcome some of the problems.

1. In order to make the scheme available to all it's important to keep the premium at low. This can be possible by the interference of the government.

Strategies :

Government can introduce some remedial measures to overcome the problems faced by these micro insurance schemes.

a) Provide financial to the NGOs. As micro insurance schemes

b) At the same time its beneficial if government removes the service tax levied on the premiums.

c) Bring the cost of medical education under control. It's possible by reducing the fees charged by the medical institutions.

d) Bring the hospital rates under control: we can see that different hospitals charge different fee for the same treatment. There should be a rate fixed by the government for the different treatments.

2. Creating awareness among the rural poor as most of them are illiterates.

3. Suggestions to users of the scheme:

a) Reduce unnecessary admissions and diagnosis in the hospitals. As some hospitals tries to grab as much as possible from the patients, if they have an insurance.

b) Willingness to pay: its possible to run the scheme if the poor people have willingness to pay the premium. There are some cases in the rural as well as urban poor that they are not ready to pay even if they can afford to pay. but there are some poor who feel secured if they have insurance. Therefore they are ready to pay the premium even if they are not able to pay.

Conclusion:

Micro insurance business holds a lot of potentials to expand and develop in India. However, the insurers must take into account the specific needs of the clients and formulate a proper solution to meet their needs at a reasonable price to the rural population. The risk assurance or risk cover offered to the clients must be easy to understand and simple to follow without any hassles as the rural clients are generally illiterate. NGOs are the reasons for the existence of micro insurance schemes in the rural India. There should be a mechanism where government also becomes the part of micro insurance schemes.

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