Short Communication

Overview of Publicly Funded Health Insurance: Tamil Nadu Model

TS Selvavinayagam, S Vijayakumar[1]

Deputy Director of Health Services, Department of Health and Family Welfare, and [1]Project Director, Tamil Nadu Health System Project, Government of Tamil Nadu, Tamil Nadu, India

Introduction

As per the World Health Organization report on health financing,[(1)] out-of-pocket payments for health can cause households to incur catastrophic expenditures, which in turn can push them into poverty. The need to pay out-of-pocket can also mean that households do not seek care when they need it. National health accounts[(2)] show that 72% of all health expenditure is made by individual households, which is one of the highest proportions in the world, and it is most regressive form of health care financing.

After taking into account the need, status of health financing and existing health insurance schemes in India, the Government of Tamil Nadu took a decision to roll out this insurance scheme.

The Government of Tamilnadu has launched the Chief Minister Kalaignar Insurance scheme for life-saving treatments on July 23rd 2009. Based on the experience from a similar scheme, "Aarogyasri"[(3)] and "Rashtriya Swasthya Bima Yojana (RSBY) Scheme,"[(4)] our project has been launched covering the entire state.

Target Group

The scheme is targeted to cover the families of the 26 welfare boards (unorganized sector) as well as families earning less than Rs. 72,000/- per annum.

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Enrollment and Issue of Smartcard

Village-wise camps were organized with 1000 teams through the insurance company across the state. During enrollment, the target group is identified through ration card and income certificate from the revenue officials. The photos and fingerprints from both thumbs of all the members of the family are taken and then data is centralized and a smartcard is prepared and distributed through district administration. As of now, more than 1.33 crore families are enrolled and have been given the smartcard.

Sum Assured, Premium and Procedures Covered

Each eligible family is insured for an amount of 1 lakh for a period of 4 years, with an annual premium of Rs. 469/ family, which is being paid entirely by the Government of Tamilnadu. A list of the various disease covered under this scheme is given by the government order[(5)] and other details of the scheme, like list of hospitals empanelled, procedures and package cost, can be accessed through their website.[(6)]

Analysis and Results

In the first year, 153,410 patients are benefited and Rs. 415 crores claims have been made. The claim ratio in the first year was 73%, excluding capacity building cost, card cost and other administrative cost, which are anticipated to increase in the future.

The age- and gender-wise utilization in Table 1, specialty-wise utilization in Table 2 and district-wise claims in Table 3 explain the progress of the scheme, which is self-explanatory.

Advantages

1. Empowers the community with choice of either

Address for correspondence:
Dr. TS Selvavinayagam, Deputy Director of Health Services, Government of Tamilnadu, 359, Anna Salai, Chennai - 600 006, Tamil Nadu, India.
E-mail: drselvavinayagam2005@yahoo.co.in

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private or public health facility.
2. Package rates with volume reduced the cost of health care.
3. Insurer is paid the premium based on the enrollment, which ensures coverage.
4. The portability in scheme, where the beneficiary can avail treatment at any part of the state, is useful to migratory workers.
5. Advanced IT elements like biometric cards and web-based claims management have been used to ensure hassle-free service delivery and uniform claim processing without any delay or corruption.
6. No age limit; everyone in the family and all preexisting diseases are included.
7. A paperless service provision model ensures that the public is not facing any hassles; they just walk in with a smart card and walk out with satisfied treatment.
8. It covers not only the poor but also the low middle class by raising the income ceiling limit to Rs 72,000 per annum, which is very unique, and it is for the first time that the middle class is also being addressed in welfare schemes.
9. The scheme is run by the insurance company directly without Third Party Administrators, which ensures timely settlement of claims and issues, if any arise.

Challenges

1. Identifying the Insurance Scheme Partner/Company in a transparent manner through open tender who can deliver the services at a competitive rate.
2. Enrollment of the eligible beneficiaries after certification by the appropriate authority without subjecting the public to hurdles is a challenge.
3. Creation of network hospitals with grading who agree to provide quality treatments at the approved package rates.

Replication in Other Parts of the Country

1. With IRDA rules and regulations governing the insurance sector in the entire country, formulating a similar insurance scheme is an easy task.
2. Training the officials and sensitizing the public can be replicable.
3. Diseases and treatment procedures are standardized to a larger extent across the nation. Additional procedures can be accommodated according to local epidemiology.
4. Use of biometric cards for the beneficiaries has helped in weeding out spurious entrants, and it has also helped in maintaining a paperless ecofriendly system that becomes part of a Web Based Claims Management System, which offers several advantages

Table 1: Age-wise and gender-wise beneficiary report (1st year policy)

Age limit (years)	Female	Amount	Male	Amount	Total	Amount
0–12	3769	159495155	6242	213442874	10011	372938029
13–20	3218	110748255	6237	182082336	9455	292830591
21–30	6939	206890959	12280	332991400	19219	539882359
31–40	12601	298208366	13839	381066485	26440	679274851
41–50	20653	405352233	14762	440119169	35415	845471402
51–60	13103	306711289	14962	465226739	28065	771938028
61–70	6896	167791699	11257	324985450	18153	492777149
71–80	1770	40581115	3983	100474826	5753	141055941
81–90	245	5764450	624	14610950	869	20375400
91–100	4	82000	26	567250	30	649250
Total	69198	1701625521	84212	2455567479	153410	4157193000

Table 2: Disease-wise number of claims versus amount spent (1st year policy)

Disease type	Number of claims	% of total claims	Amount spent in crores	% of total cost	Cost of single procedure
Orthopedics	31660	20.6	94.7	22.82	29911.56
Oncology	26039	17.0	38.65	9.31	14843.12
Urology	18497	12.1	41.53	10.01	22452.29
ENT	14931	9.7	28.62	6.90	19168.17
Cardiac diseases	14638	9.5	120.72	29.09	82470.28
Hysterectomy	12344	8.0	15.9	3.83	12880.75
Others	19742	12.9	41.53	10.01	21036.37
Total	153410	Total	415	100%	27051.69

ENT: Ear nose throat

Table 3: District-wise claims summary (1st year policy)

Districts	No. of claims approved	Amount (Rs.)
Ariyalur	1207	24432000
Chennai	5079	223285000
Coimbatore	13822	379161000
Cuddalore	4125	125978000
Dharmapuri	4030	121889000
Dindigul	8701	206714000
Erode	11740	260062000
Kancheepuram	4282	144566000
Kanyakumari	6899	146190000
Karur	3976	102590000
Krishnagiri	3324	111118000
Madurai	4758	106773000
Nagapattinam	2855	82766000
Namakkal	8256	205379000
Nilgiris	1200	32726000
Perambalur	2417	65419000
Pudukkottai	3092	81548000
Ramanathapuram	2394	53936000
Salem	8860	254789000
Sivagangai	2754	61029000
Thanjavur	5057	130688000
Theni	3004	69887000
Tirunelveli	3879	98583000
Tirupur	5940	141978000
Tiruvallur	2347	77165000
Tiruvannamalai	3396	112689000
Tiruvarur	2879	75983000
Trichy	7340	203854000
Tuticorin	2446	56168000
Vellore	3859	149782000
Villupuram	5452	168089000
Virudunagar	4040	81977000
Total	153410	4157193000

for maintenance and growth. The IT infrastructure in use can easily be copied and used with minimal changes to accommodate the magnitude of the beneficiaries.

Scalable

Although it covered the intended beneficiary at the entire state level, there is still scope for the expansion of the scheme, where the Above Poverty Line population and the organized private sector groups can join the scheme by paying the premium themselves.

Sustainability

This scheme enjoys the patronage of the state administration and has the complete acceptance of the society. The annual expenditure outlay toward this scheme amounts to Rs. 750 crore, which is manageable and sustainable.

Issues that Need to be Addressed

There is a need for external evaluations of the performance and possibility of integration with RSBY.

Quality Issues

The Empanelment and Disciplinary Committee, Mortality and Morbidity Committee Vigilance Committee, Ortho/Cardiac/Cochlear Committee, Inspection Committee and Redressal Committee at the district level under the chairmanship of the district collector look into the quality issues.

With all the above factors, this scheme ensures that benefits actually reach the intended beneficiaries directly/entirely without any pilferage, which can be a model for other states to adopt with suitable modifications.

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